Petition

81-860

No. _____

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

ALVIN R. YAPALATER, M.D.,
Petitioner, Pro Se,

—v.—

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,
Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

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QUESTIONS PRESENTED FOR REVIEW

1. Whether the H.H.S. position is correct?
2. Whether the Court's decision with respect to the scope of the practice of medicine is correct?
3. Whether the respondents illegally restrict the profession of psychiatry and illegally maintain their monopoly over the rendition of outpatient psychiatric services.
4. Whether the decision violates the legislative intent of the Social Security Act with respect to mainstreaming, right of choice and comparability of services for the medicaid clients?

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Review of Care

A. Out-patient care

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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

No._____

ALVIN R. YAPALATER, M.D.,

PETITIONER, PRO SE

-vs-

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State

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Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

RESPONDENTS.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

The Petitioner, pro se, Alvin R. Yapalater, respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit decided on March 25, 1981.

OPINION BELOW

The United States Court of Appeals for the Second Circuit entered its opinion on March 25, 1981 affirming on the memorandum opinion and order of the United States District Court for the Southern District of New York, Charles S. Haight, Jr., Judge, Civ. No.80-1794 (S.D.N.Y. July 30, 1980), holding that "Yapalater is entitled to assert his claim under §1983, but dismissing his complaint on the merits." Petition for rehearing was denied and filed August

10, 1981. The Opinion of the Court of Appeals is in the Appendix* pp A 1 - A 6. The memorandum opinion of the District Court is in the Appendix pp A 10 - A 94. The ORDER of the the Court of Appeals denying the petition for rehearing is in the Appendix pp A 7 - A 9.

JURISDICTION

On March 25, 1981 the Court of Appeals entered its opinion affirming the memorandum opinion and order of the United States District Court Southern District of New York July 30, 1980 affirming petitioner's entitlement to assert his claim under 42 USC 1983, but dismissing his complaint on the merits.

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*Pages of the Appendix are prefixed A.

On August 10, 1981 the Court of Appeals made and entered an ORDER denying a Petition for Rehearing; pp A 7 - A 9. The jurisdiction of this Court is invoked under 28 USC 2101(c).

CONSTITUTIONAL PROVISIONS, STATUTES; REGULATIONS INVOLVED

United States Constitution, Amendment XIV:

> "...nor shall any State deprive any person of life, liberty, or property, without due process of law, nor deny to any person within its jurisdiction the equal protection of laws."

Social Security Act Title XIX

42 USC:

§ 1320a - 2	§ 1396a(a)(23)
§ 1396 et seq.	§ 1396a(a)(30)
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42 USC:

§ 1983

42 CFR:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT MEDICAL ASSISTANCE PROGRAM P.1.

New York Education Law:

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State Medical Handbook Item 46.4

Review of Care

A. Out-patient care

STATEMENT OF THE CASE

Petitioner for many years a private practicing psychiatrist in Westchester County, sued complaining of refusal of County and New York State Officials to approve his medicaid reimbursement claims ($20,275.) for physician's services rendered by ancillary therapists under his personal supervision. This service delivery system consisted of standard therapists: social worker, psychologist, counsellors, under Petitioner's guidance

treating self-paying patients, and after 1966, medicaid patients in the same manner. Petitioner's position within the lawsuit was predicated not only upon an "equal protection" claim but also upon a statutory claim, ie, the United States Department of Health and Human Services* interpretation of its own 42 CFR 440.50 which reads:

> "Physicians' services, whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided--
>
> (a) Within the scope of practice of medicine or osteopathy as defined by State law; and
>
> (b) By or under the personal supervision of an individual licensed under

---

* hereafter H.H.S. or H.E.W.

State law to practice
medicine or osteopathy."

Statutory Claim:

H.H.S. had been engaging in a "compliance issue" with the State over the regulation in question with respect to the requirements of New York State's State Plan for Medical Assistance under Title XIX of the Social Security Act. The H.H.S. opinion is contained within extensive correspondence held with the State officials between 1978 and 1980, as occasioned by complaints of other psychiatrists. These H.H.S. opinions are reproduced within the Appendix pp. A 95 - A 162. H.H.S. pointed out that "...it is not the (State) [Medicaid] agency's perogative to delineate whom a physician may employ to provide services under his supervision. This is delineated by those

state laws which define the parameters within which any physician may practice." Seeing that the parameters of the customary practice of psychiatry under New York State law allowed for the psychiatrist to render treatment by personally supervising and taking professional responsibility for social workers, psychologists, paraprofessionals and other therapists, H.H.S. was successfully pressing the State Agency to comply with approiate implementation of 42 CFR 440.50 within the State Plan. This is evidenced within pp. A 163 to A 196 which render correspondence between the New York State Department of Health and the State Legislature. Additionally, H.H.S. indicated that it spoke authoritatively with respect to the categories of physician extenders which a psychiatrist could

supervise under 42 CFR 440.50(b); see pp A 95 - A 120.

Moreover, Petitioner argued that Medicaid Freedom of Choice Provisions (42 USC 1396a(a)(23); 42 CFR 431.51) and the comparability provision were being violated inasmuch as medicaid recipients were not permitted to be treated within his office on the same basis as were self-paying patients.(42 USC 1336(a)(10))

"Equal Protection" Claim:

Petitioner argued that he was denied the "equal protection of laws" because while denying him reimbursement the State Medicaid Agency reimbursed to state operated and/or controlled facilities for the rendition of psychiatrist supervised services performed therein by those same categories of ancillary personnel

that psychiatrists historically and customarily supervised in their practices.

Due Process Claim:

Petitioner asserted due process violation inasmuch as Defendants provided no notice or opportunity for a hearing, but flatly refused to deal with his claim to qualified provider status under 42 CFR 440.50.(b):

> "(b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."

District Court's Action:

The District Court took jurisdiction under 28 USC § 1331(a) and alternatively under 28 USC § 1343(3). The District Court held: (1) 42 USC § 1983 provided a remedy; (2) the State Defendants were

not required to reimburse Petitioner's services under 42 CFR 440.50(b) inasmuch as these services did not constitute the practice of medicine where under present state law such ancillary personnel were excluded from the scope and practice of medicine; (3) there was no equal protection claim under the rational standard; (4) Defendants' gradual recognition of the role of ancillary personnel in private practice of psychiatry did not violate equal protection, notwithstanding reimbursement for services of ancillary personnel rendered in state certificated psychiatric clinics.

The trial was consolidated with the hearing of application for preliminary injunction; FRCP 65(a)(2). The Appendix material, ie, the H.E.W. opinions (pp A 95 - A 156), was before the Court as

was the New York State Department of Health Opinions/Fact Finding Reports to the New York State Assembly Ways and Means Committee (pp A 163 - A 196) and the Official Position of the Medical Society of Putnam County (pp A 197 - A 201). There was no testimony from anyone in H.H.S. Thus H.H.S.' additional input to the trial was limited to the letter from the H.H.S. Regional attorney within the Appendix pp A 157 - A 162. There was no discovery.

REASONS FOR GRANTING THE WRIT

1. The H.H.S. Statutory position is correct; the Court of Appeals has "violated" the primary judisdiction doctrine. A prestigeous Federal Agency should not be so summarily routed without

an opportunity for clarification. It is curious that state bureaucrats should contend and show that they know the Social Security Act and the regulations thereunder better than disinterested H.H.S. The Petitioner here unwittingly has short-circuited a typical "state v. H.H.S." compliance struggle as clearly illustrated in Rosado v. Wyman 90 S.Ct. 1207 (1970) pp 1225 - 1227. The observations of the dissenting opinion in Rosado p. 1227 are well-applied in this current case which no doubt would not have reached this Court, had the Petitioner known ab initio not to go beyond the data contained within the letters of the New York State Department of Health to the New York Assembly Ways and Means Committee (A 163-A 196). However, Rosado also says, quoting Helvering v.

Davis, 301 U.S., 619, 645, 57 S.Ct. 904, 910, 81 L.Ed. 1307; p. 1226:

> "When money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by the Congress, not the states."

All of Public Health and Welfare, H.H.S. its agent, and in this case Title XIX are definitively shaped by the Congress. Even an amateur's acquaintenance with the legislative history of the Public Laws shows total authorship in Congress of what should happen in any local social services district. Neither is the state a poorly treated 50% subscriber to the program. 42 CFR 432.50; 42 CFR 433.15 show high per centage Federal investment in states' staffing and training expenditures, claims processing, certain facilities' inspection,

family planning services, and 90% for State Medicaid Fraud and Control Units (A 218 to A 228). In return for such largese, the State signs a Medicaid Plan (A 259-A 260) and agrees to abide by its provisions, "the requirements of Titles XI and XIX of the Act, all applicable Federal regulations and other official issuances of the Department [H.H.S.]" The definition and mechanics of the State Plan are set out in 45 CFR Part 200 (p. A 234-p.A 258). 45 CFR 201.3 (c) (p.A 236) informs that the H.H.S. Regional Medicaid Director is the agent exercising delegated authority to take affirmative action in state plans on the basis of policy statements or precedents previously approved by the Administrator who retains authority for determining what is approvable or not in a state

plan with any final disapproval requiring prior consultation and discussion with the Secretary. Thus in return for compliance with the Federal intentions the state plan becomes approved 45 CFR 201.3 (e) (p.A 238) and grants are made (p. A 243). Clearly in executing the medicaid program Congress has gone out of its way not only to prescribe the services quality of the Medicaid Act but also to see to it that the state is well supported in its execution of administrating Title XIX; in short, no "onus" (p. A 61) or unfairness has been laid upon the state.

The dispute within this case must in part depend upon whether or not H.H.S.' interpretation of 42 CFR 440.50(b) ".. is of controling weight [or] is plainly erroneous or inconsistent with the regulations." Bowles v. Seminole Rock Co.,

325 U.S. 410, 414. (1944). If H.H.S. interpretation be of controling weight, there is then no problem with the lower court's finding with respect to the scope of medical practice. H.H.S. position is of controling weight. No agency could possibly know more about health care personnel than does H.H.S. which has on multiple occasions be called upon by the Congress to study health case personnel (P.L. 94-484 eg at 42 USC § 292, p. A 278). Also P.L. 91-519, P.L. 92-603 (A 272-278) has been located at 42 USC 1320a-2 and applies generally to Social Security and is TITLE XI referred to within the State Plan supra. This statute we respectfully submit settles the issue; H.H.S. may establish criteria for health care personnel (see p. A 202-A 204); it throws common sense light

upon the conceding statements of the New York State Department of Health to the New York Assembly Ways and Means Committee. "...any services customarily within the scope of the practice of medicine could be reimbursed to the doctors..." This point likewise applies effectively to the Court's decision:

> "Neither the Social Security Act nor the Federal regulations specify who those individuals may be... are we confronted with a wide open field... supervising psychiatrist has carte blanche... witch doctors to administer therapy... varieties of exotic therapists...methods highly suspect... doubt exists as to the remedial steps that could be taken..." (pp. A 60- A 62)

See also 45 CFR 201.3(d). "Guidelines are furnished to assist in the interpre-

tation of regulations [by H.S.S.];" one such example of a guidelines is at pp. A 102-A 120. Further, those ancillary personnel who render psychiatric services under supervision within state certificated facilities had to be approved by H.H.S. with the State Plan; thus any independent psychiatrist may supervise these individuals in providing services to medicaid clients (42 USC § 1320a-2 (b)). Neither should the Court's incorporation of the Baehm Affidavit ¶¶ 8-9 with respect to the spectre of "psychiatric service 'mills' where a small number of psychiatrists employ a large number of auxilliary personnel and develop a large practice based on the provision of low grade psychiatric case by paraprofessionals with little or no meaningful

supervision by a psychiatrist" affect as a scare tactic (pp. A 79-A 80). The nature of H.H.S.' activity was not a shotgun approach (see pp. A 154-A 156). The fact is that there is medicaid fraud and abuse (pp. A 279-A 284), but psychiatry which is predicated upon personal relationship is less likely than other medical services to lend itself to the "mill" approach. Moreover, the Medicaid agency's rule for Review of Care applies to clinic and to independent psychiatrists alike pursuant to the requisite State Medical Handbook (pp. A 269-A 271); 42 CFR § 456.1 (p. A 232).

2. The decision's holding that the state bureaucracy's medicaid regulations and the provisions within the state Education Law for the registration of physicians' and specialists' assistants

limit the scope of the practice of medicine violates and misrepresents the legislative intent of New York State and of the Congress. To say as the Court did (p. A 59),that these are "limitations upon a private practitioner's right to reimbursement for services rendered to Medicaid eligible patients" in New York State is certainly true; but the predicate thereof can not be due to the legislature's intent to limit the scope of the practice of medicine. The Court apparently thought that the State Department of Education was involved (p. A 80), but the Court on p. A 80 would be accurate had it said "...Social Services and Health...". The fact is that every New York statute which defines the physician or the practice of medicine:

New York Education Laws §

6521 (p. A 261)

New York Education Law §
6522 (p. A 261)

New York Public Health Law
§ 3700 (p. A 262)

defines in the same broad way. This latitude is carried forward from the state's legislative history, from the state attorney general's opinion in 1908 and again in 1933 (p. A 285-A 287) where the physician has latitude to take responsibility for an employee and also may have a practice as extensive as is the definition thereof. The same latitude is found within the definition of the practice of medicine within the Laws of New York 1947 (p. A 288). From the Court's decision at p. A 26 and at pp. A 165, A 197-A 201; it is readily seen that independent psychiatrists within the state use ancillary personnel in the rendition of outpatient services; yet no one seeks to

arrest these physicians for acting beyond the scope of license. The Court calls upon the New York Education Law 6532(1) and (2) - physicians' assistants and specialist to find limitations to the scope of medical practice. A comparison of the Governor's Memoranda (pp. A 289-294) upon approving these physicians' associates and specialist's laws on July 6, 1971 with P.L. 91-519 Health Training Improvement Act of 1970 (pp. A 272-A 276) shows the origin of these New York Laws to be Federal for Congress' purpose of expanding and improving health care. Yet within the decision, the Court is going in the opposite direction. Moreover, the New York State legislature within the Mental Hygiene Law § 31.02 (p. A 265-A 268) did not apparently share the bureaucrats

restrictive intent, but excepted from the operating certificate requirement for a "facility...for the rendition of outpatient...services for the mentally disabled...professional practice within the scope of a professional licensure...by an individual practitioner or by a partnership of such individuals or by a professional service corporation..."

Lastly Mr. MILLS says within the Legislative History P.L. 89-97 U.S. Code Cong. and Adm. News. p.2292 (see p. A 272):

> "...It has never been our intention to limit the authority of physicians who have been licensed under State law..."

A licensed physician has a vested right to practice his profession without interference. People v. Sabourin, 1938, 166 Misc. 23, 2 N.Y.S. 2d 728; Peo. v.

Dobbs Ferry Med. Pav., 40 A.D. 2d 324 pp. 327, para 2, 330 para 3.

3. The Respondents are illegally restricting the profession of psychiatry and illegally maintain there monopoly over the rendition of out-patient psychiatric care. This is the position of Dr. Block of the Putnam County Medical Socity (pp. A 197-A 201). The contrast between the Respondents' position as delineated within the communications with the New York State Assembly Ways and Means Committee is striking. Within this case a discovery would have been beneficial. Yet the material available clearly indicates purposeful discrimination against independent psychiatrists: 5% of 5% of the total medicaid payout in New York is to private psychiatrists (p. A 168) this is significant. Like-

wise the respondents claim as reported within the decision: "More recently the evaluation of new approaches in psychiatric care and an increased use generally of ancillary personnel led to a re-evaluation of reimbursement regulations in this area...social workers...under...a qualified psychiatrist..." (pp. A 78-A 79). This claim is not worthy of belief in view of the activity of H.H.S. Further the respondents' characterizing the fees paid for a social worker as "cost effective" (p. A 58) is not correct inasmuch as at $15.00 per hour it is not a living wage where social work fees in 1977 for private work are reported between $25.00-$35.00 per individual session and $15.00 per individual in a

group session.* See 42 CFR § 447.204 (p. A 232). This will enlist virtually no providers for medicaid clients. Thus independent practice for social workers and psychiatrists appears to be in discouragement. All of the foregoing constitutes "a showing of clear and intentional discrimination..." Snowden v. Hughes, 321 U.S. 1, 8, 64 S.Ct. 397, 401, 88 L.Ed. 497.

State controlled facilities are not threatened in a medicaid monopoly with often bloated cost-based rates; see 42 U.S.C. 1396a (a)(30) (p. A 213-A 214).

4. The Courts decision violates the legislative intent of the Social Security

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*Encyclopedia of Social Work, 17th Issue, NASW, 1977 p. 1056; the starting full-time salary for a social worker is $25,000.00 plus benefits.

Act with respect to mainstreaming, right of choice and comparability of services.

The acknowledged purpose of the Medicaid program was to help recipients to attain or retain capability for independence or self-care and have access to private practitioners of their choice (42 U.S.C. § 1396) and to bring the poor into the mainstream of American medical services. Hearings before the Subcommittee on Medicaid and Medicare of the Senate Finance Committee, 91st Cong., 2d Sess., pt. 1 at 57 (1965). Congress required that the program be in effect in all parts of the participating state (42 U.S.C. § 1396(a)(1); that services for which the state pays be comparable for covered groups (42 U.S.C. § 1396a(a)(10)(B)); and that the program be administered in the "best

interests of the recipients" (42 U.S.C. § 1396a(a)(19)). In 1968, Congress added provisions establishing a system of reviewing use and quality of care. 42 U.S.C. § 1396a(a)(30). It permitted Medicaid recipients to choose health care providers according to their own preference. 42 U.S.C. § 1396a(a)(23). Section 1396a(a)(23) is commonly referred to as the "freedom of choice" provision.

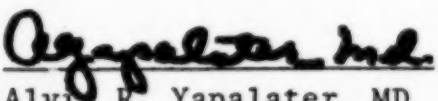
Thus the Courts decision forecloses the opportunity to the Medicaid clients to be treated here on the same basis as self-paying clients. (42 U.S.C. § 1396a (a)(30)). Bay Ridge Diagnostic Laboratory Inc. v. Dumpson, 400 F.Supp (E.D. N.Y., 1975) p.1106.

CONCLUSION

For all of the foregoing reasons, Petitioner prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals.

Dated: November 1, 1981

Respectfully submitted



Alvin R. Yapalater, MD
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APPENDIX

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

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No.827, 905-September Term, 1980

(Argued February 24, 1981 Decided March 25, 1981)

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*

ALVIN R. YAPALATER, M.D., F.A.P.A.,

Plaintiff-Appellant,

-v-

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant,

Defendants-Appellees,

and

BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

Defendant-Appellees-Cross-Appellants.

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Before:

OAKES and KEARSE, Circuit Judges,

and NEAHER, District Judge.*

*

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Appeal from a judgment by the United States District Court for the Southern District of New York, Charles S. Haight, Jr., Judge, dismissing plaintiff psychiatrist's complaint that refusal by state and county officials to reimburse him for Medicaid services a-legedly provided by individuals under his supervision violated Title XIX of the Social Security Act, 42 U.S.C. §§1396-1396i, and

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* Of the United States District Court for the Eastern District of New York, sitting by designation.

federal regulations promulgated thereunder, as well as the equal protection clause of the Constitution, U.S. Const. amend. XIV, § 1. Cross-appeal by defendant state officials from district court's ruling that plaintiff psychiatrist had a private federal cause of action.

Affirmed on the opinion below.

*

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*

MARC E. GROSSMAN (Evelyn K. Isaac, Fahey & Isaac, White Plains, New York, of counsel), for Plaintiff-Appellant.

ELLEN J. BRONZO, Assistant Attorney General (Robert Abrams, Attorney General of the State of New York,

George D. Zuckerman, Assistant Solicitor General, New York, of counsel), for Defendants-Appellees-Cross-Appellants.

SAMUEL S. YASGUR, Westchester County Attorney, Jonathan Lovett, Deputy County Attorney, Eric D. Koster, Senior Assistant County Attorney, of counsel, White Plains, New York, for Defendants-Appellees.

SETH P. STEIN, Seligman, Stein & Abramowitz, Garden City, New York, for the New York State Psychiatric Association as Amicus Curiae.

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*

PER CURIAM:

We affirm on the memorandum opinion and order of the United States District Court for the Southern District of New York, Charles S. Haight, Jr., Judge, Civ. No. 80-1794 (S.D.N.Y. July 30, 1980), holding that Yapalater is entitled to assert his claim under §§1983, but dismissing his complaint on the merits.

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

At a Stated Term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Court House, in the City of New York, on the tenth day of August, one thousand nine hundred and eighty-one.

Present:

Hon. James L. Oakes,

Hon. Amalya L. Kearse,

Circuit Judges.

Hon. Edward R. Neaher,

District Judge.

Alvin R. Yapalater, M.D., F.A.P.A.

Plaintiff-Appellant,

v. 80-7755

Charles W. Bates, individually and as

Westchester County Commissioner of Social Services, and Henry J. Lefkowits, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant,

Defendants-Appellees,

and

Barbara Blum, Individually and as New York State Commissioner of the Department of Social Services; William Steibel, Individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); Robert P. Whalen, Individually and as Commissioner of the New York State Department of Health; Albert Demartino, Individually and as Director of the White Plains Regional Office of the New York State Department of Health; and Lois Eil, Individually as Medical Di-

rector, Westchester County Division of Medical Assistance of the New York State Department of Health,

Defendants-Appellees-Cross-Appellants.

O R D E R

Treating the "Motion to Reenter Judgment" as a petition for rehearing, the petition for rehearing is denied and our mandate previously recalled and stayed may go down in due course.

James L. Oakes

Amalya L. Kearse

Circuit Judges.

Edward R. Neaher

District Judge.

United States Court of Appeals
Filed August 10, 1981
A. Daniel Fusaro, Clerk
Second Circuit

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

----------x

ALVIN R. YAPALATER, M.D., F.A.P.A.,

Plaintiff,

-against-

CHARLES W. BATES, Individually and as Westchester County Commissioner of Social Services; BARBARA BLUM, Individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, Individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, Individually and as Commissioner of The New York State Department of Health; ALBERT DEMARTINO, Individually and as Director of the White Plains Regional Office of the New York State Department of Health; LOIS EIL, Individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health; HENRY J. LEFKOWITS, M.D., Individually and as Westchester County, Department of Social Services, Psychiatric Consultant,

Defendants.

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80 Civ. 1794-CSH

MEMORANDUM OPINION AND ORDER

APPEARANCES:

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Attorney for State Defendants
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Ellen J. Bronzo, Esq.,
Assistant Attorney General,
Of Counsel.

HAIGHT, District Judge:

Plaintiff Alvin R. Yapalater, M.D., is a psychiatrist practicing in White

Plains, Westchester County, New York. He is a provider of services under New York State's Medicaid Plan, which is funded in part by the federal government pursuant to Title XIX of the Social Security Act, 42 U.S.C. §1396 et seq.

Defendants Charles W. Bates, Albert DeMartino, Lois Eil, and Henry J. Lefkowits, M.D. (the "County defendants") are concerned with the administration of the Medicaid program on the Westchester County level. Defendants Barbara Blum, William Steibel, and Robert P. Whalen (the "State defendants") are charged with administration of the Medicaid program on the State level. Plaintiff's claims for Medicaid reimbursement are submitted in the first instance to the County defendants, who make an initial evaluation, and determine whether or not to

pay them, thereafter making claims for partial reimbursement from the State, which in turn makes a claim for partial reimbursement from the federal government. In their evaluation of Medicaid-reimbursement claims, the County defendants are guided by regulations and policy decisions emanating from the State defendants.

Plaintiff has been practicing psychiatry in White Plains for a number of years. Medicaid patients have formed a significant part of his practice. At present, about 75% of his 300 patients are Medicaid recipients.[1] [A88] In his practice Dr. Yapalater employs psychologists, psychiatric social workers, psychiatric nurses, and behavioral therapists. These individual work with patients, under plaintiff's supervision. The State de-

fendants have refused to approve reimbursement of Dr. Yapalater for the services of these individuals. The County defendants have consequently declined to process plaintiff's reimbursement claims.

Plaintiff claims that this refusal violates Title XIX and federal regulations promulgated thereunder. He also asserts constitutional deprivations of due process and equal protection. Dr. Yapalater sues for declaratory and injunctive relief, punitive damages, and costs including attorney's fees. Jurisdiction was originally asserted under 28 U.S.C. §1331(a),[2] [A88] it being alleged that the matter in controversy exceeds the sume of $10,000. Following filing of the first amended complaint, the Supreme Court decided Maine v. Thiboutot, 48 U.S.L.W. 4859 (decided June 25, 1980).

The plaintiff thereupon moved to amend his complaint further, so as to state a cause of action under 42 U.S.C.§1983,[3] [A88] and to claim attorney's fees under §1988. That application was granted, and the complaint deemed amended accordingly.

The action first came before the Court on plaintiff's motion for preliminary injunction pursuant to Rule 65, F.R. Civ.P., and defendants' cross-motion under Rule 12(b) to dismiss the complaint for legal insufficiency. The Court directed that the trial of the action be advanced and consolidated with the hearing of the application for preliminary injunction. Rule 65(a)(2). The parties having offered the testimony of witnesses and documentary exhibits, briefs having been submitted and oral argument heard, the case is now ready for final adjudi-

cation. The following constitute the Court's Findings of Fact and Conclusions of Law. Rule 52(a), F.R.Civ.P.

I.

At the threshold defendants challenge the Court's subject matter jurisdiction.

In Chapman v. Houston Welfare Rights Organization, 441 U.S. 600 (1979), the Supreme Court held that 28 U.S.C. §1343 (3) and (4)[4] [A89] did not encompass, within its jurisdictional grant, claims by welfare recipients that a state welfare regulation was invalid because it conflicted with the Social Security Act. Section 1343 did not confer federal jurisdiction over claims based on the Social Security Act, the Court held, because the Act did not secure "equal rights," the predicate to jurisdiction under §1343(3), or "civil rights," the jurisdi-

ctional predicate under §1343(4). Since the recipients' claims did not exceed $10,000, general federal-question jurisdiction was not available under §1331(a). Even assuming there was a viable claim under the Civil Rights Act, 42 U.S.C. §1983, the Court concluded that statute did not secure "equal rights" or "civil rights" within the meaning of §1343, and afforded no independent basis for jurisdiction, since in the words of the Third Circuit's opinion, affirmed in Chapman, §1983 "is not a jurisdictional statute; it only fashions a remedy." 441 U.S. at 606.

Maine v. Thiboutot, supra, answering the question assumed in Chapman, held that 42 U.S.C. §1983 encompassed welfare recipients' claims based upon a state's purely statutory violations of the Social

Security Act, thereby making available the right to claim attorney's fees under §1988. The case commenced in the state court, and so no federal jurisdictional question arose; but the Court, in dictum, reconciled its decision with Chapman by recognizing that §1983 was broader than its so-called jurisdictional counterpart in §1343. 48 U.S.L.W. at 4861 n.6. The gap in jurisdictional coverage could, as in Thiboutot, be filled by a state court's general subject matter jurisdiction, or, as recognized in Chapman, by general federal-question jurisdiction under §1331, and presumably by the grant of diversity jurisdiction under 28 U.S.C. §1332.

Defendants argue, within the context of what is said to be a jurisdictional defense, that Thiboutot, which involved

welfare recipients, did not overrule sub silentio Cort v. Ash, 422 U.S. 66 (1975); and that under the Cort analysis,[5] [A89] plaintiff as a welfare provider has no federal right of action for an alleged violation of the Social Security Act under color of state law.

Defendants' Cort v. Ash argument, even if sound, does not defeat the Court's jurisdiction. Rather, the argument goes to the merits, and is addressed infra. Jurisdiction of the plaintiff's §1983 claim for violations of the Social Security Act is properly founded upon 28 U.S.C. §1331(a), as "arising under the Constitution, laws, or treaties of the United States." The district court in Cort held that it had jurisdiction under §1331, Ash v. Cort, 350 F. Supp. 227, 232 (E.D.Pa. 1972), a conclu-

sion which the Supreme Court did not question, although holding that the underlying federal statute did not create a private cause of action.

To be sure, §1331(a) requires a $10,000 jurisdictional amount. The present defendants contend that the $10,000 jurisdictional amount is not satisfied.

Where the question is raised at the pleading stage, a complaint alleging the jurisdictional amount will stand unless "upon the face of the complaint, it is obvious that the suit cannot involve the necessary amount," Saint Paul Mercury Indemnity Co. v. Red Cab Co., 303 U.S. 283, 292 (1937). The affidavits accompanying the complaint and motion for preliminary injunction alleged that plaintiff was owed $20,375 as the result of defendants' allegedly wrongful interpre-

tation of the Medicaid regulations. While defendants argue that a number of these claims have been held up because of facial or other irregularities not related to the regulations at issue in the case, it is not necessary to inquire further into the details of these invoices, in order to determine the existence vel non of the jurisdictional amount. First, even if we were concerned solely with plaintiff's claim for invoices previously rendered, one cannot say from the face of his complaint that the jurisdictional amount could not be met; and it is well settled that a federal court does not lose jurisdiction over a case originally well-founded, simply because the amount ultimately recovered falls short of $10,000. Rosado v. Wyman, 397 U.S. 397, 405 n.6 (1970).

A leading commentator has stated: "...the jurisdictional amount test is not dependent upon the amount actually recovered by plaintiff. Otherwise, the court's jurisdiction would be uncertain and some adjudications of the merits would be subject to a condition subsequent." 14 Wright-Miller-Cooper, Federal Practice and Procedure (1976) at §3702, p. 381.

Secondly, the present complaint also contains a prayer for injunctive relief, "ordering defendants to conform their policy and procedure for outpatient services to federal law..." Thus the object of the suit is to enjoin the enforcement of the state regulations and policy declarations. It is "the value of this object thus sought to be gained that determines the amount in dispute."

Packard v. Benton, 264 U.S. 140, 142 (1924). Plaintiff presently treats about 300 patients, of which 75% are Medicaid recipients, and employs a number of ancillary personnel in furtherance of their treatment, for whose services defendants refuse reimbursement. These are circumstances from which it sufficiently appears that the value of plaintiff's right to conduct his practice free of the reimbursement limitations presently imposed by the state exceeds the jurisdictional amount. Packard v. Benton, supra, at 143; Allway Taxi, Inc. v. The City of New York, 340 F.Supp. 1120, 1126 (S.D.N.Y. 1972).

Accordingly, I conclude that jurisdiction over plaintiff's claims for federal statutory violations may be had under §§1331(a).

As an alternative basis of jurisdiction, plaintiff asserts a constitutional claim under the Equal Protection Clause. That claim arises from the undisputed fact that the state reimburses under Medicaid the services of ancillary personnel rendered under a physician's supervision in psychiatric clinics, while refusing to reimburse comparable services supervised by a physician in private practice such as plaintiff. Defendants dispute the merits of the equal protection claim. But the claim supports jurisdiction under 28 U.S.C. §1343(3) unless it is "either so frivolous or so insubstantial as to be beyond the jurisdiction of the District Court." Hagans v. Levine, 415 U.S. 528, 539 (1974); and see cases cited at 542-543. Plaintiff's equal protection claim cannot be so

characterized. I am cited to no case which clearly forecloses it. The state's conceded granting of Medicaid reimbursement for services rendered by ancillary personnel in clinics, and denial of reimbursement for the same services in a private practice setting, require equal protection analysis. It follows that §1343(3) gives this Court jurisdiction over plaintiff's equal protection claim, no jurisdictional amount being required, and over the statutory claim on prinicples of pendent jurisdiction, Hagans at 536, the jurisdictional amount in those circumstances no longer being applicable.[6] [A91]

Defendants' jurisdictional challenge is rejected.

II.

Plaintiff's Statutory Claim

Plaintiff claims that the defendants' refusal to reimburse him for services rendered by his ancillary personnel violates pertinent federal regulations. In a series of letters directed to the state agencies by the regional office of the United States Department of Health, Education and Welfare (now the Department of Health and Human Services, and referred to hereinafter as "HHS"), the federal agency has articulated an interpretation of its regulations consistent with plaintiff's claim, which would mandate Medicaid reimbursement for the services of plaintiff's ancillary personnel. Those letters were prompted by inquiries concerning other physicians, but plaintiff summons them to his aid. The regional office has also written to the Court in response to my inquiry concern-

ing this litigation.[7] [A91]

The State defendants have adopted, and urge in this litigation, an interpretation of the pertinent federal regulations which permits the state to deny plaintiff Medicaid reimbursement for his ancillary personnel. The State defendants do not, as I understand them, deny that their regulations and practices must conform to federal regulations. The issue is whether or not the state regulations and practices are consistent with federal regulations.

As noted ante, the State defendants first contend that plaintiff, a provider of Medicaid services rather than a recipient, has no private federal cause of action under the Social Security Act and regulations. Defendants framed their initial attack on the complaint before

the Supreme Court decided Maine v. Thiboutot, supra. They relied upon Chapman, supra, for the proposition that an alleged conflict between federal and state regulations did not give rise to a constitutional claim under 28 U.S.C. §§1343(3); and that plaintiff could not prevail under §1331(a) because no cause of action on behald of a provider could be implied from the Social Security Act, relying upon Cort v. Ash, supra, and its progeny.

During the pendency of this trial, the Supreme Court decided Maine v. Thiboutot, supra. We must conjure with its effect upon the case at bar. Thiboutot involved claims by welfare recipients that state action violated the Social Security Act. The Court held that 42 U.S.C. §1983 fashioned a remedy for such

claims; and that 28 U.S.C. §1331(a) conferred jurisdiction if the $10,000 amount was present.[8] [A91] Applicability of the §1983 remedy to a claim of state Medicaid inconsistency with the Social Security Act is recognized by the Thiboutot majority's reference to Blue v. Craig, 505 F.2d 830 (4th Cir. 1974) (claim by recipients that North Carolina's Medicaid plan was inconsistent with the Social Security Act), 48 U.S.L.W. at 4862, and by Mr. Justice Powell's observation in dissent that among other areas, "Medicaid...may provide particularly inviting subjects of litigation." Id. at 4865.

Defendants say Thiboutot avails plaintiff nothing because he is a welfare provider, not a recipient, and that the Cort v. Ash analysis, not overruled by

Thiboutot, precludes a private right of action. Defendants stress the first Cort element, that the plaintiff be "one of the class for whose especial benefit the statute was enacted" (emphasis added), and make the point that the Social Security Act was specially intended to benefit needy recipients, not practicing physicians or other providers of welfare services.

I agree with defendants that Thiboutot does not overrule Cort; but I conclude that the Thiboutot rationale necessarily limits the applicability of the Cort analysis, where deprivation results from state action conflicting with federal statutory law. Mr. Justice Powell, dissenting in Thiboutot, described its impact on litigation:

> "In practical effect, today's decision means

> that state and local governments, officers, and employees may now face liability whenever a person believes he has been injured by the administration of any federal-state cooperative program, whether or not that program is related to civil rights." 48 U.S.L.W. at 4865 (emphasis in original).

In a footnote appended to this language, Mr. Justice Powell continues:

> "The only exception will be in cases where the governing statute provides an exclusive remedy for violations of its terms." Ibid.

That summary of Thiboutot's effect appears entirely accurate. On what basis, then, is plaintiff to be denied a §1983 remedy? If plaintiff is correct in his interpretation of governing regulations, the state has deprived him of Medicaid reimbursement to which he is legally entitled. He has, therefore,

"been injured by the administration" of a federal-state cooperative program. The State defendants' contention concedes plaintiff's injury and, arguendo, their own maladministration, but would rebuff plaintiff without remedy because he is a mere "provider." I perceive nothing in §1983 or the Court's rationale in Thiboutot which would permit, let alone require, such a limitation. Furthermore, within the §1983 context, it distorts reality to characterize plaintiff as nothing but a "provider." To be sure, it was as a "provider" that plaintiff furnished Medicaid services; but the case at bar turns upon the legal measure of his reimbursement. Thus he may be just as accurately described as a "recipient of reimbursement." He claims that wrongful administration of the Medicaid program by

by the state deprives him of reimbursement to which federal law entitles him. In my judgment, §1983 as interpreted by the Thiboutot majority furnishes this plaintiff a remedy.

Had Mr. Justice Powell's analysis constituted the majority opinion in Thiboutot, then the existence vel non of a private cause of action on plaintiff's behalf may well have turned upon the analysis in Cort v. Ash and its progeny: a more doubtful proposition from plaintiff's point of view. However, the precise effect of Thiboutot is to create a remedy where (as the present plaintiff clearly alleges) injury flows from a state's violation of governing federal law in a joint federal-state cooperative program. If those elements are present, §1983 provides the private

remedy; and there is simply no occasion to inquire whether the underlying statute also provides one, by express terms or implication. The only pertinent inquiry, as Mr. Justice Powell pointed out in his footnote, is whether the governing statute "provides an exclusive remedy for violations of its terms" (emphasis added). No such provisio- appears in the Social Security Act.

I conclude, therefore, that plaintiff is entitled to assert his claim under §1983. I have previously held that the jurisdictional amount under 28 U.S.C. §1331(a) is satisfied.

I now consider the pertinent statute and regulations, together with the differing interpretations put forward by federal and state agencies. Since, as we shall see, the decisive regulation was

promulgated by the federal agency, pursuant to authority derived from the Social Security Act, I must consider the Court's proper role. "In construing administrative regulations, 'the ultimate criterion is the administrative interpretation, which becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation.'" United States v. Larionoff, 431 U.S. 864, 872 (1977), quoting from Bowles v. Seminole Rock Co., 325 U.S. 410, 414 (1945). But the degree of deference may vary with circumstances. In Kurcsics v. Merchants Mutual Ins. Co., 49 N.Y.2d. 451, 459, 426 N.Y.S.2d 454, 458 (1980), the New York Court of Appeals stated:

> "Where the interpretation of a statute or its application involves knowledge and understanding operational practices or entails an evaluation of

> factual data and inferences to be drawn therefrom the courts regularly defer to the governmental agency charged with the responsibility for administration of the statute. If its interpretation is not irrational or unreasonable, it will be upheld. (Matter of Howard v. Wyman, 28 N.Y.2d 434, 322 N.Y.S. 2d 683, 271 N.E.2d 528; cf. Ostrer v.Schenck, 41 N.Y. 2d 782, 786, 396 N.Y.S. 2d 335, 337, 364 N.E.2d 1107, 1109.) Where, however, the question is one of pure statutory reading and analysis, dependent only on accurate apprehension of legislative intent, there is little basis to rely on any special competence or expertise of the administrative agency and its interpretive regulations are therefore to be accorded much less weight. And, of course, if the regulation runs counter to the clear wording of a statutory provision, it should not be accorded any weight. (See Matter of Adams [Government Employees Ins. Co.] , 52 A.D.2d 118, 121, 383 N.Y.S. 2d 319, 321."

While the cited decisions are from

New York courts, they are consistent with federal authority.

(a) Federal Interpretation

HHS begins its analysis with the Medicaid provisions of the Social Security Act, 42 U.S.C. §§1396 et seq. A state which participates in the Medicaid program must include coverage of physicains' services in its state plan, and provide reimbursement for such services. That follows from 42 U.S.C. §1396a(a), which provides:

> "A State plan for medical assistance must--
>
> "(13) provide--
>
> "(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under sub-

> chapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d(a) of this title..."

The categories of care and services listed in clauses (1) through (5) of 42 U.S.C. §1396d(a) include, in clause (5):

> "physicians' services furnished by a physician (as defined in section 1395x(r)(1) of this title), whether furnished in the office, the patient's home, or hospital, or a skilled nursing facility, or elsewhere;..."

The definition contained of a "physician" in 42 U.S.C. §1395x(r)(1), the Medicare provisions of the Social Security Act thus incorporated by reference in Medicaid, provides in pertinent part as follows:

> "The term 'physician', when used in connection with the performance of any function or action,

> means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action..."

HHS has promulgated regulations pursuant to statutory authority.[9] [A91] Central to the present case is the regulation appearing at 42 C.F.R. §§440.50, which HHS states in its letter to the Court was promulgated by the Secretary "to define physicians' services." That section of the regulations reads in its entirety:

> "'Physcians' [sic] services,' whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided--
>
> "(a) Within the scope of practice of medicine or osteopathy as defined by State law; and
>
> "(b) By or under the personal supervision of an individual licensed under

State law to practice
medicine or osteopathy."

In prior correspondence with the State defendants, members of HHS's regional staff have taken the position that §§440.50 mandates reimbursement of ancillary personnel who render psychiatric services under the supervision of a physician. For example, on October 5, 1978 the regional attorney of HHS wrote to defendant Steibel. "It has come to our attention," HHS begins, "that Westchester County is refusing to provide reimbursement to physicians for care rendered by social workers under their direct personal supervision." HHS quotes the County's expressed view that social workers may not be reimbursement directly, and that "the fact that they may be providing services under the supervision of a private psychiatrist or psychologist

does not enable that psychiatrist or psychologist to bill under his name for service they provide." The HHS letter of October 5, 1978 agrees that social workers "cannot be directly reimbursed as individual providers under the New York State Medicaid plan," but goes on to say that "the quoted statement concerning reimbursement to a private physician for care rendered by social workers under his supervision is incorrect." The HHS letter then quotes §§440.50(b), and continues: "Accordingly, you must reimburse for physician's services that are rendered under a licensed physician's supervision. Private physicians, therefore, may, indeed, be reimbursed under Medicaid for care rendered under their personal supervision even if the care is rendered by a social worker." The HHS letter

refers to a report that reimbursement was being denied a psychiatrist "who personally supervised social workers in treating psychiatric patients." The letter continues: "Denial of reimbursement in that case is a violation of your state plan and Federal Medicaid requirements."

In a letter dated February 7, 1979 addressed by Arthur J. O'Leary, Regional Medicaid Director, to defendant Blum, HHS expanded its interpretation of §§440.50 beyond social workers. That letter offers the following discussion:

> "'Physicians' services' are defined in 42 CFR 440.50 as services provided 'within the scope of practice of medicine or osteopathy as defined by State law; by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.' As we stated previously this

> regulation makes FFP available not only for services provided by a physician licensed and practicing according to State law, but also makes FFP available to the physician for services of professionals and paraprofessionals employed by him and functioning under his supervision. In the latter instance the physician professionally accepts responsibility for the work of the nurse, social worker or other individual under his supervision. Both counsel here in our Regional Office as well as our central office staff have concurred that the services of the employed professional or paraprofessional fall within the category of 'physicians' services' and are reimbursable as such." [A92] (emphasis in original).[10]

That employees other than social workers were contemplated appears clearly from the second page of O'Leary's letter, which suggests to the state "another more appropriate billing code available for

use by psychiatrists submitting claims for patient treatment or counseling provided by social workers, or psychologists or other counselors under their supervision." Thus O'Leary suggested that defendant Blum consider establishing a separate billing code for use by private psychiatrists, when billing for therapy "provided as individual or group counseling by social workers, psychologists, or other therapists."

These letters were written by HHS to the State defendants entirely without regard to the present plaintiff's claim, but plaintiff obtained copies and summons them to his aid. As noted ante, the Court asked HHS to comment with respect to this litigation. The letter in reply from the regional attorney, after summarizing the statutory background and

quoting §§440.50, goes on to state:

> "In order for services to be reimbursable as physicians' services within the meaning of this provision, the requirements of subsections (a) and (b) must be met. Therefore a service must be one within the State law definition of the scope of practice of medicine or osteopathy and provided by or under the personal supervision of a licensed medical or osteopathic physician. Reimbursement may not be withheld solely because an otherwise reimbursable service is provided under the personal supervision of a physician rather than by him or her directly. The State may, of course, decline to reimburse a service if it is not within State law definition of the scope of practice of medicine or osteopathy or if it is provided without the actual personal supervision of a licensed physician. In addition, it is within the State's authority to set appropriate fees for reimbursement depending on the nature of the service rendered."

(emphasis in original).

The regional attorney also attached copies of prior correspondence "for your further information." Among the correspondence attached were the two prior letters from which I have quoted. I am bound to say that, while I appreciate the assistance of HHS, the discussion most recently quoted can be read in more than one way. Indeed, counsel for all parties at oral argument professed to find support in various phrases of the letter; and a debate ensued as to the proper interpretation of the agency's interpretation. However, it is logical to conclude that by attaching copies of the agency's prior correspondence to its letter to the Court "for your further information," HHS intended to ratify and reaffirm the interpretations contained in those earli-

er letters. If that is a fair reading, then HHS persists in its contention that, by denying reimbursement to psychiatrists for the services of these ancillary personnel, the State defendants violate federal law and regulations.

That is the interpretation urged by the present plaintiff. In his submission, the State and County defendants are required by federal law to reimburse him, at the scheduled fee for his own services and for all services rendered, under his supervision, by his entire ancillary staff: social workers, psychologists, nurses, and other therapists.

(b) The State's Interpretation

The State defendants' interpretation focuses upon the requirement, in §§440.50, that "physician's services" be provided

"within the scope of practice of medicine...as defined by State law." Defendants' argument is set forth in a letter dated January 15, 1979 addressed to Mr. O'Leary of HHS by David P. Blasel, Deputy Commissioner and General Counsel of the New York State Department of Social Services:

> "It appears clear that a State may cover certified social workers under the Medical Assistance Program, and receive Federal reimbursement for payments for those services, where State law defines those services as within the scope of the practice of medicine. This statement is true whether the services are provided directly by a physician, or under his personal supervision.
>
> "The operative part of this statement, however, is the phrase 'where State law defines those services as within the scope of the practice of medicine.' In my opinion, the services

> of a certified social worker are not, under the laws of New York State, within the scope of the practice of medicine. This opinion is universally shared by other officials of this Department, and has been expressed by the Department of Health.
>
> "Furthermore, the question is one purely of State law and, therefore, of State interpretation. Under the concept of the Federal grant programs, Federal officials have no interest in interpreting State laws, and no authority to interpret State laws. In this particular instance, the scope of services covered as mandated 'physician services' under Federal law and regulations is left, by the same law and regulations, to the provisions of State law."

Commissioner Glasel concludes his letter to O'Leary with this defiant broadside:

> "I therefore reaffirm the decision of this State that the services of a certified social worker are not within the scope of the practice

> of medicine in New York State, even though provided under the direction of a physician or psychiatrist; that those services cannot therefore be covered under the Medical Assistance program in this State; and that we intend to continue to deny claims for physician services that were in fact provided by certified social workers, and to recover any overpayments made on claims submitted in that circumstance, unless and until State law is changed."

The state has applied the same policy to ancillary personnel other than social workers, such as psychologists, therapists, or other counselors. The state has persisted in this policy, despite a reply from Mr. O'Leary's office that HHS was not persuaded by the state's arguments: hence, ultimately, this litigation.

Thus defendants' basic contention is that the services of a supervising

physician's ancillary personnel are not reimbursable under §§440.50(a) unless the services of the ancillary personnel fall "within the scope of practice of medicine...as defined by State law." The nub of plaintiff's argument, apparently endorsed by HHS, is that it is sufficient if only the supervising physician, licensed under State law as required by subsection (b), renders services "within the scope of practice of medicine...as defined by State law." The ancillary personnel, on the face of this construction, could be literally anybody.

(c) The State Statutes and Regulations

To place these contentions in context, I turn to the New York State statutes and regulations cited by defen-

dants.

Title 8VIII of the N.Y. State Education Law (McKinney 1972 & 1979-80 Supp.) is captioned "The Professions." Article 131 refers to "Medicine." Section 6521 provides:

> "The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition."

Section 6522 provides:

> "Only a person licensed or otherwise authorized under this article shall practice medicine or use the title 'physician'."

Section 6542(1) and (2) provide that, notwithstanding other provisions of law, a "physician's assistant" and a "specialist's assistant" may "perform medical services, but only under the supervision of a physician," and only when his acts

and duties "are within the scope of practice of such supervising physician." Section 6541 of the Education Law provides for registration of physician's assistants and specialist's assistants. The Commissioner of Public Health is empowered to promulgate regulations defining the assistants' duties, the degree of supervision required, and establishing medical specialties for which specialist's assistants may be registered under the Education Law. N.Y. Public Health Law §§3700, 3701 (McKinney 1977). Under present regulations, physician's assistants may be registered in the clinical fields of medicine, surgery, pediatrics, and obstetrics and gynecology; and specialist's assistants may be registered in orthopedics, urology, acupuncture, and radiology. 10 N.Y.C.R.R.

§§94.1, 94.2

Medicaid reimbursement to physicians in New York is governed by regulations promulgated by the Department of Social Services, 18 N.Y.C.R.R. §§505.1 et seq., and the Department of Public Health, 10 N.Y.C.R.R. §§85.1 et seq. "Medical care and services available to eligible persons" includes "services of qualified physicians," 18 N.Y.C.R.R. §505.1(1), who must be licensed or qualified as provided in §505.2(1)(i) (general practitioners) and (ii) (specialists), psychiatry constituting one of the recognized specialties. 18 N.Y.C. R.R. §505.15 deals particularly with psychiatric care. "Psychiatric care" may be provided by a "qualified psychiatrist" in his office; in the patient's home; in a clinic; or in hospitals.

§505.15(a). "Psychiatric clinic care" may be provided "only in facilities or services which have been approved by the State Department of Mental Hygiene," §505.15(b) (2)(i), and which consist of clinics situated in hospitals supervised by the State Department of Health pursuant to Article 28 of the Public Health Law; clinics operated by the State Department of Mental Hygiene; and clinics under contract with or operated by community mental health boards. §505.15(b) (2)(ii).

10 N.Y.C.R.R. §§85.28-85.31 govern Medicaid reimbursement of "outpatient psychiatric care." §85.28(b) and (c) provide:

> "(b) A private practicing physician is a physician who renders treatment to a patient on a fee-for-service basis and who is compensated for those

> services directly through the medical assistance for the needy program, except that payment for services may be made directly to a professional corporation or partnership in which the private practicing physician is a member or with which the private practicing physician is associated.
>
> "(c) To be a covered benefit under medical assistance for the needy as provided in section 365-a.2 of the Social Services Law, outpatient psychiatric care rendered by a private practicing physician must be provided by a qualified psychiatrist in accordance with the requirements of sections 85.28 through 85.31 of this Part."

A new regulation, §85.32, has been promulgated and, when fully implemented, will be effective retroactively to January 30, 1980. It provides:

> "(a) Social work services may be provided by a social worker, practicing under the

> direct supervision of a qualified psychiatrist in private practice as part of a course of treatment provided by the supervising psychiatrist.
>
> "(b) For purposes of this section, the term social worker shall mean a person authorized pursuant to the Education Law to use the title 'certified social worker'." (emphasis in original).

The regulation further provides that "a social worker may provide services only under the continuing direct supervision of a qualified psychiatrist," and that "the number of social workers supervised by the supervising psychiatrist shall not exceed four." The social worker's functions must be assigned "by the supervising psychiatrist, within the scope of practice of the supervising psychiatrist," §§85.32(c)(2). Payment for social work services are made to the

supervising psychiatrist; state reimbursement is limited to the maximum reimbursable fees for social work, §85.32(e)(1), (2). The new regulation is characterized as "cost effective, since such care is reimbursed at a substantially lower level than that provided directly by psychiatrists."[11] [A92] Companion amendments to 18 N.Y.C.R.R. §505.15, also to become effective as of January 30, 1980, provide that in the delivery of psychiatric care, "a qualified psychiatrist in private practice may utilize the services of a certified social worker under his supervision as part of a course of treatment," §505.15 (a); a psychiatrist "may employ up to four certified social workers to provide care under his continuing direct supervision," §505.15(b)(1); state

reimbursement will be based on fees established by the Department of Health, with payment for the social worker's services made to the supervising psychiatrist. §505.15 (b)(2)(i).

(d) The Court's Analysis

From these statutes and regulations emerge limitations upon the scope of the practice of medicine, as defined by New York State, and consequent limitations upon a private practitioner's right to reimbursement for services rendered to Medicaid-eligible patients. The decisive question on plaintiff's statutory claim is whether, notwithstanding those limitations, the state must reimburse plaintiff, at a psychiatrist's fee rate, for services rendered by a variety of ancillary personnel, excluded under present state law from

the scope of the practice of medicine.

I answer that question in the negative. I could accept plaintiff's interpretation--and that of HHS, if the agency's letter to the Court of July 8, 1980 be read as an unqualified endorsement of its prior correspondence--only by disregarding the authority given to the states by the Social Security Act,[12] [A92] and by §440.50 itself, to define the scope of medical practice within their borders.

Subsection (b) of §440.50 unquestionably makes federal Medicaid funding available in respect of services rendered "by or under the personal supervision" of a licensed physician. It follows that the regulation contemplates reimbursement for the services of individuals other than a physician. Neither the Social Security Act nor the federal

regulations specify who those individuals may be. The question therefore arises: are we confronted with a wide open field, or do limitations derive from state statutes and regulations? Plaintiff contends for the first of these propositions. It is implicit in his argument. The supervising psychiatrist has carte blanche. I put it to plaintiff's counsel during argument that, on plaintiff's interpretation, a supervising psychiatrist could employ witch doctors to administer therapy, and claim reimbursement for their services at the physician's rate. Counsel responded that state authorities had the power to investigate excessive witch doctoring in White Plains, and take remedial steps. But there is no reason why the onus should be on the

state to conduct such investigations, and, under plaintiff's regulatory construction, considerable doubt exists as to the remedial steps that could be taken. If plaintiff's interpretation of §440.50 is correct, the psychiatrist in private practice could demand reimbursement for the services of unlimited varieties of exotic therapists, whose methods may be highly suspect under generally accepted medical standards.

I do not suggest that Dr. Yapalater engages in such abuses, or entertains hopes of doing so. On the contrary, he appears to me from the evidence to be an experienced and dedicated physician. But the potential risk is real enough; and the state is entitled, under §440.50(a), to require that services, to qualify for Medicaid reimbursement, be provided

"within the scope of practice of medicine...as defined by State law." New York State has gone to considerable legislative and executive pains to define the scope of the practice of medicine. That scope is not strictly limited to physicians--vide the physician's assistants; specialist's assistants; and the certified social workers recently brought within the scope of the practice of psychiatry--but plaintiff's interpretation, which stresses the "under the personal supervision" phrase in §440.50 (b), would admit to the Medicaid-reimbursable scope of practice of medicine the services of a host of individuals whom the state has deliberately excluded from its definition of that practice. That is a construction of subsection (b) which deprives subsection (a) of most of

its practical meaning.

I appreciate that it is possible to read §440.50 as plaintiff does; he argues that since he is a licensed physician, unquestionably practicing within the state's definition of the scope of medical practice, the regulation opens up an umbrella, under which all individuals employed and supervised by him cluster as providers of "physician's services." I must choose between that narrow reading of subsection (a)'s phrase "within the scope of practice of medicine ...as defined by State law," and the more broad construction urged by defendants, which, while recognizing that the physician need not perform all services himself to be reimbursed, requires that his employees render services which the state recognizes as falling

within the scope of the practice of medicine.

I prefer the latter construction because it constitutes a more balanced interaction between subsections (a) and (b); and because it gives more meaningful recognition to the state's interest in defining the practice of medicine within its borders. That state interest is rendered more significant, not less, by the fact that under Medicaid federal reimbursement is only partial, so that substantial state revenues are expended in funding the program.

The Court's construction runs counter to that of HHS, at least as expressed in its earlier correspondence with the state defendants. However, the agency's letter of July 8, 1980 to the Court, quoted ante, contains its own ambigui-

ties; thus it is said: "The State may, of course, decline to reimburse a service if it is not within the State law definition of the scope of practice of medicine or osteopathy, or if it is provided without the actual personal supervision of a licensed physician." (emphasis added). Surely that sentence can be read to support the defendants' construction; and one senses, in the agency's response to an inquiry from the trial court in a litigated case, a possible retreat from the dogmatic tones with which HHS addressed the state agencies. Assuming, however, that HHS presses its interpretation with undiminished enthusiasm, I cannot accept it; and since the issue is one of "statutory reading and analysis," Kurcsics, supra, I may differ with the agency without over-

stepping the bounds of accepted judicial behavior.

Plaintiff's statutory claim is rejected.

The Equal Protection Claim

As previously noted, plaintiff's equal protection claim arises from the undisputed fact that the state allows Medicaid reimbursement to hospital and clinic providers of psychotherapeutic services which are performed by non-physician clinicians working under the supervision of licensed psychiatrists. Contending that he offers the identical services in substantially similar circumstances, Dr. Yapalater claims that the defendants' refusal to reimburse him for the very same treatment regimen creates an impermissible distinction

between psychiatrists in private practice and psychiatrists employed in other settings.

By way of background, Dr. Yapalater testified that he structures his practice along the lines of the "typical mental health model." Dr. Yapalater explained that he has long believed in community-based outpatient treatment of both mild and severe mental illness. Accordingly, drawing on his exposure to clinics in the Westchester County area, Dr. Yapalater adopted a mental health team approach to the treatment of mental disorders, modeled after the clinics with which he had become familiar. Thus, Dr. Yapalater contends, his practice is structured in the very same way as public-sector mental health clinics are organized; given the identity of services and

parallel structure, Dr. Yapalater argues, it is violative of the Equal Protection Clause of the fourteenth amendment to deny him Medicaid reimbursement while allowing such payment to these other providers.

The basic framework for analysis of such a claim is well-settled:

> "We must decide, first, whether [state legislation] operates to the disadvantage of some suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution, thereby requiring strict judicial scrutiny... If not, the [legislative] scheme must still be examined to determine whether it rationally furthers some legitimate, articulated state purpose and therefore does not constitute an invidious discrimination...." Maher v. Roe, 432 U.S. 464 (1977), quoting San Antonio School Dist. v. Rodriquez, 411 U.S. 1, 17 (1973).

Accord, Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307, 312, 314 (1976). Clearly, Dr. Yapalater does not fall within any of the limited categories of disadvantaged classes which require strict judicial scrutiny for purposes of equal protection analysis. Nor does the central question of this case involve a fundamental right explicitly or implicitly protected by the Constitution. Accordingly, plaintiff's equal protection claim requires examination of the state's policy of allowing reimbursement under the New York State Medical Assistance Program to community clinics and hospitals for services provided by non-physician therapists, while denying payment to psychiatrists in private practice for such services. I find that defendants have fulfilled their burden in estab-

lishing a legitimate purpose which is rationally related to and therefore justifies the distinction at issue.

In attempting to articulate the basis for differentiating between hospitals and clinics on the one hand, and private practitioners on the other, for purposes of Medicaid reimbursement of services performed by non-physicians, defendants point to several elements which are meant to distinguish the operation of public sector facilities from that of a physician in private practice, and which in their view amply justify the distinction at issue herein. Defendants rely upon the nature of the regulatory scheme under which the respective treatment settings operate; the structure of the reimbursement mechanism pursuant to which each seeks payment under the New York

Medical Assistance Program; and the scope of accepted medical practice in each of these delivery modes. Affidavit of Donald W. Baehm, sworn to June 20, 1980 ("Baehm Affidavit"), passim.

It cannot be disputed that hospitals and clinics are subject to a host of statutory and regulatory controls to a degree far beyond that applicable to private practitioners. The pertinent provisions of the statute and regulations under which public sector facilities exist need not be exhaustively recited in order to recognize that the state intrudes into virtually every facet of their operation. Hospitals, for instance, are subject to the strictures of Article 28 of the Public Health Law, which vests near-complete regulatory authority in the Department of

Health. That agency has promulgated a maze of regulations affecting every significant medical, financial and organizational element of hospital operation. See Public Health Law §2800 et seq. (McKinney 1977 and 1979-80 Supp.); 10 N.Y.C.R.R. §400 et seq. Similarly, in order to be eligible for reimbursement for operating costs, clinics must operate under contract to local community services boards pursuant to an operating certificate authorizing the particular services for which payment is sought; such facilities are subject to joint regulation by the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities and the Office of Alcohol and Substance Abuse, which are component but autonomous parts of the New York State Department of Mental

Hygiene. See Mental Hygiene Law §5.01 et seq. (McKinney 1978 and 1979-80 Supp.) As in the case of the Department of Health's regulation of hospitals, the Department of Mental Hygiene prescribes comprehensive regulations governing virtually every aspect of the construction, operation and staffing of public mental health clinics. See 14 N.Y.C.R.R. §1.1 et seq.

In comparison, privately practicing psychiatrists operate largely free of such comprehensive regulation, save for compliance with their individual licensure requirements as set forth in the New York State Education Law.

In general, defendants regard the reimbursement mechanisms as paralleling the foregoing operational controls in scope and complexity. Hospitals, it is

conceded, are reimbursed under Medicaid according to their historical costs of operation, receiving reimbursement for in-patients based upon a daily rate and for out-patients based upon a per visit rate.

Clinics operating under contract are eligible for reimbursement of certain operating, maintenance and service costs. In addition, in-patient clinics receive reimbursement on an all-inclusive per diem basis, see 10 N.Y.C.R.R. §100.2(k); out-patient psychiatric clinics operated by general hospitals receive reimbursement on a per visit basis according to rates established by the Department of Health for each particular hospital based on the facility's actual costs, 10 N.Y.C.R.R. §100.2(m)(1); all other out-patient psychiatric clinics

receive reimbursement on a fee-for-service basis under a fee schedule set forth in regulations promulgated by the Department of Mental Hygiene. 10 N.Y.C.R.R. §§100.2(m)(2).

Finally, reimbursement for treatment rendered by a psychiatrist in private practice is authorized by Section 365-a of the New York Social Service Law and is made according to a published medical fee schedule and is not based on an individual practitioner's costs.[13][A92] Baehm Affidavit at ¶ 4.

In essence, defendants submit that these differences in the scope of regulation and the manner of calculating reimbursement reflect trends in the practice of psychiatry which have only recently begun to develop, trends which the state in the exercise of its informed

discretion has recognized in the most recent amendments to the regulations governing reimbursement for social workers in the private setting.

More specifically, defendants contend that the reimbursement scheme is meant to parallel the generally recognized scope of practice in each provider category; accordingly, reimbursement to private practitioners for services rendered by non-physicians was not available because "in the past it was not a commonly accepted practice for private psychiatrists to employ social workers or other paraprofessionals as a component of treatment in a private setting." Baehm Affidavit, ¶ 7. Thus, until recently, "(n)o provision was made for reimbursement for psychiatric services (delivered in the private sector) pro-

vided by other than a qualified psychiatrist." Id. at ¶ 5.

However, in recognition of emerging trends in the practice of psychiatry and medicine generally,[14] [A93] the state has begun the process of aligning its reimbursement of private practitioners with that of other providers:

> "8. More recently the evolution of new approaches in psychiatric care and an increased use generally of ancillary medical personnel led to a reevaluation of reimbursement regulations in this area. A determination was made that carefully controlled and delineated reimbursement for psychiatric care by certified social workers, working under the close supervision of a qualified psychiatrist would be appropriate and beneficial. Part 85 of the regulations was therefore amended by the addition of §85.32, which provided for reimbursement for psychiatric social work provided by qualified social workers. Section 85.32 requires that such social workers be 'under continuing direct supervision of

a qualified psychiatrist' and limits to a maximum of four the number of social workers a single psychiatrist can supervise. It should also be noted that psychiatric care provided by social workers can be highly cost effective, since such care is reimbursed at a substantially lower level than that provided directly by psychiatrists.

"9. Section 85.32 carefully delineate(s) the psychiatric services that may be provided by social workers and the degree of supervision that must be provided by a psychiatrist. In addition, only care provided by qualified social workers is reimbursable under Medicaid. Other auxiliary or paraprofessionals are not covered under §85.32. These carefully structured controls and restrictions are designed to prevent the creation of psychiatric service 'mills' where a small number of psychiatrists employ a large number of auxiliary personnel and develop a large practice based on the provision of low-grade psychiatric care by para-professionals with little or no meaningful supervision by a psychiatrist." Baehm Affidavit, // // 8-9.

It is perhaps fair to say that Dr. Yapalater is on the cutting edge of the generally recognized scope of psychiatry as practiced by individual physicians. Indeed, his efforts to graft modes of treatment employed in hospital and clinic settings onto his private practice may well be those of an innovative pioneer. But the question before me is whether the defendants' present position satisfies the applicable equal protection tests. The most recent amendments promulgated by the New York State Departments of/Education/[sic] and Health, which will permit private psychiatrists to secure reimbursement for services by social workers performing under their supervision, reflect the state's policy of incremental growth in the scope of Medicaid reimbursement, as the frontiers

of the private practice of psychiatry expand. To find a violation of equal protection in these circumstances would require a conclusion that it is unreasonable to permit the state to proceed in this area in a gradual fashion, with such limits and controls as defendants consider necessary. No such conclusion is warranted on this record.

That the present state of the law respecting reimbursement imposes some inequality between plaintiff and providers in other settings delivering comparable services does not compel a conclusion that Dr. Yapalater's constitutional rights have been infringed. Dandridge v. Williams, 397 U.S. 471 (1970). The classification drawn into question herein must be sustained if it is rationally related to a legitimate

governmental interest. United States Dept. of Agriculture v. Moreno, 413 U.S. 528 (1973). Thus, the interests protected by the Equal Protection Clause require only that the reimbursement scheme have some reasonable basis. Massachusetts General Hospital v. Weiner, 569 F.2d 1156, 1160-61 (1st Cir. 1978). The interests protected by the Equal Protection Clause are not implicated simply because the regulations do not act with mathematical nicety or because their impact results in some inequality between provider categories, Massachusetts General, supra, 569 F.2d at 1160-61; "[p]erfection in making the necessary classifications is neither possible nor necessary." Massachusetts Board of Retirement v. Murgia, 427 U.S. 307, 314 (1976).

It is not the mission of the courts to decide whether the balance of competing interests reflected in the current reimbursement regulations is wise economic or social policy. Cf. Harris v. McRae, 48 U.S.L.W. 4941, 4949 (June 24, 1980). The only requirement of equal protection is that the state's actions be rationally related to a legitimate governmental interest. The articulated purpose in recognizing for reimbursement purposes the expanding role of paraprofessionals in the private practice of psychiatry by means of regulatory controls, which furnish the necessary oversight to assure continued high-quality psychiatric care, constitutes a sufficient basis for sustaining the defendants' present regulations against equal protection attack. Nor is the state's

interest in preventing the creation of psychiatric service "mills" entitled to any less weight because Dr. Yapalater himself may provide the highest quality care imaginable.

If the New York Medical Assistance Plan's reimbursement to individual psychiatrists is under inclusive, in the sense that the use in private practice of paraprofessionals other than certified social workers is becoming generally accepted, this shortfall in the reimbursement mechanism does not rise to the level of a constitutional violation; "[i]t is no requirement of equal protection that all evils of the same genus be eradicated or none at all." Railway Express Agency, Inc. v. New York, 336 U.S. 106, 110 (1949). See Vance v. Bradley, 440 U.S. 93, 108-09 (1979).

The state is entitled to expand its reimbursement of the services at issue herein by means of the measured approach it has adopted. In the interim, the reimbursement classifications presently in force work no deprivation of Dr. Yapalater's interests in equal protection.

The Equal Protection Clause might well be implicated if defendants reimbursed the services of ancillary personnel employed by certain psychiatrists in private practice, while denying it to others. But no such practice appears; on the contrary, the evidence indicates that the state's policy is applied uniformly to all psychiatrists in private practice. The state's gradual recognition of the role of ancillary personnel in the private practice of

psychiatry is constitutionally permissible, representing as it does a rational approach to an adequately articulated public concern. No equal protection implications arise from the fact that, in the quite different contexts of hospitals and public mental health clinics, the state is prepared to allow a broader based policy of reimbursement.[15] [A94]

CONCLUSION

The Clerk of the Court is directed to enter judgment in favor of defendants, dismissing the complaint without costs.

In the exercise of my discretion, I direct that each party bear its own costs. While I have concluded that plaintiff's action must fail, it can hardly be regarded as frivolous, in view of the HHS correspondence upon which he relied.

It is So Ordered.

Dated: New York, New York
July 30, 1980

Charles S. Haight, Jr.

CHARLES S. HAIGHT, JR.
U. S. D. J.

FOOTNOTES

1. Considerable reference was made at trial to Psychiatric Services Center, Inc., a not-for-profit corporation Dr. Yapalater has used in the past as a vehicle for rendition of his services. The legal status of that corporation is now engaging the attention to the state courts. None of the issue is pertinent to the case at bar.

2. Section 1331(a) provides:

> "The distrist courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitutuin, laws, or treaties of the United States."

3. Section 1983 provides:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable

> to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

4. Section 1343 provides in pertinent part:

> "The district courts shall have original jurisdiction of any civil action authorized by law to be commenced by any person:...
>
> "(3) To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States;
>
> "(4) To recover damages or to secure equitable or other relief under any Act of Congress providing for the the protection of civil rights, including the right to vote."

5. That analysis is:

> "First, is the plaintiff

'one of the class for whose especial benefit the statute was enacted,' Texas & Pacific R. Co. v. Rigsby, 241 U.S. 33, 39 (1916) (emphasis suppled) --that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? See, e.g., National Railroad Passenger Corp. v. National Assn. of Railroad Passengers, 414 U.S. 453, 458, 460 (1974) (Amtrak). Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? See, e.g., Amtrak, supra; Securities Investor Protection Corp. v. Barbour, 421 U.S. 412, 423 (1975); Calhoon v. Harvey, 370 U.S. 134 (1964). And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law? See Wheeldin v. Wheeler, 373 U.S. 647, 652 (1963); cf. J. I. Case Co. v. Borak, 377 U.S. 426,

434 (1964(; Bivens v. Six Unknown Federal Narcotics Agents, 403 U.S. 388, 394-395 (1971); id., at 400 (Harlan, J., concurring in judgment)." 422 U.S. at 78.

6. Holley v. Lavine, 605 F.2d 638, 647 (2d Cir. 1979).

7. See letter directed to the Court under date of July 8, 1980 by Annette Blum, Assistant Regional Attorney, and attached correspondence, collectively marked Court Ex. 2 at trial.

8. The Thiboutot Court dealt with the jurisdictional amount in a footnote:

> "There is no inherent illogic in contruing §1983 more broadly than §1343(3) was construed in Chapman v. Houston Welfare Rights Organization, supra. It would only mean that there are statutory rights which Congress has decided cannot be enforced in the federal courts unless 28 U.S.C. §1331(a)'s $10,000 jurisdictional amount is satisfied." 48 U.S.L.W. 4861 at n.6.

9. 42 U.S.C. §1302.

10. "FFP" means "Federal Financial Participation." It refers to the partial reimbursement for Medicaid expenditures available from the federal government to the states.

11. Affidavit of Donald W. Baehm, New York State Department of Health, at paragraph 8.

12. The states determine whether a physician is authorized to practice medicine. 42 U.S.C. §1395x(r)(1).

13. Thus, the state's contention that the distinction under attack is justified upon the basis of differences in the manner in which reimbursement is calculated --historical cost versus fee-for-service--rests upon a flawed premise insofar as a subset of out-patient clinics receives payment on the same basis as private psychiatrists. Taken alone, then, the second element of differentiation defendants articulate fails as a matter of proof with respect to the limited category of clinic providers which operate under contract to community service or mental health boards. It is true, of course, that payment to such providers is made to the clinic qua institution and not to the individual presumable salaried physician under whose supervision ancillary personnel may provide therapy,

an element of difference not raised by defendants. These flaws aside, the other purposes to which defendants point as underlying the distinction at issue are sufficient to carry the day.

14. The legislature discussed the underlying needs and economic realities in its statement of legislative findings and purpose relating to the 1971 law providing for physician's and specialist's assistants:

> "The existing shortage of physicians and other persons possessing adequate qualifications for the provision of health services required by the people of this state constitutes a critical situation imperiling the public health. Many areas of the state lack adequate medical coverage due to the insufficient number and uneven distribution of practicing physicians. The demand for physician services far exceeds the capability of the present number of physicians to supply them. Physical limitations on the number of patients a physician can personally attend make the use of persons

> qualified to assist the physician in the provision of medical care essential if such care is to be uniformly available to all of the people of the state.
>
> "It is the purpose of this act [enacting this article and article 38 and article 131-A of the Education Law] to provide for the registration of physician's associates and specialist's assistants who will be available for employment by physicians to permit medical services to be given to persons not receiving them now and whose qualifications will assure that the health needs of patients are met properly." McKinney (1972), note following Public Health Law, §3700.

15. As noted, the complaint alleges in purely conclusory fashion a violation of plaintiff's right to due process. Plaintiff adduced no evidence on this claim at trial, nor was any reference made to a purported deprivation of due process in counsel's closing argument. Accordingly, the claim is deemed abandoned.

DEPARTMENT OF HEALTH, EDUCATION,

AND WELFARE

May 17, 1978

William Steibel, DDS
Deputy Commissioner
Division of Medical Assistance
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Mr. Steibel:

This is in regard to the attached correspondence which refers to physicians' services under Medicaid. The appropriate regulatory citation, 42 CFR 449.10(b)(5) (formerly 45 CFR 249.10(b)(5)) "Physicians Services" under Amount, Duration, and Scope of Medical Assistance, states:

> "Physicians' services, whether furnished in the

> office, the patient's home, a hospital, a skilled nursing home or elsewhere. 'Physicians' services' are those services provided within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."

The above means that the services performed by persons employed by a physician, such as social workers, psychologists, nurses, etc., are covered for Medicaid reimbursement provided that such services are under the personal supervision of the physician. The physician bills and receives Medicaid reimbursement in accordance with the established fee schedule.

With regard to "personal supervision," the regulation does not further define the context of such supervision. The

regulation permits each State to establish the degree of personal supervision which physicians should exercise. The degree of "personal supervision" notwithstanding, there are no statutory or regulatory barriers to pay for services of physicians' assistants such as social workers, psychologists, nurses, etc., under Medicaid.

Sincerely,

Enclosure

DeSantis
Supervisory Medicaid Specialist

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
MEDICAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

INFORMATION MEMORANDUM

MSA-IM-16

July 31, 1972

TO: STATE AGENCIES ADMINISTERING APPROVED MEDICAL ASSISTANCE AND PUBLIC ASSISTANCE PLANS

SUBJECT: The Physician Assistant

CONTENT: In an era of increased demand on the health services delivery systems in this country, many innovative approaches have been developed to extend the services of physicians. The most visible of these efforts has

been in the area of the allied health occupations. One of the fastest emerging roles in this area is that of the Physician's Assistant (PA). (emphasis added)

This is of special interest to governmental programs providing or reimbursing medical services. Already the MSA Central Office has received inquiries from several Regional Offices on the question of reimbursement for services provided by Physicians' Assistants or similar persons. These inquiries have asked if the PA can be directly reimbursed and if there are requirements for the degree of

supervision of PA activity by a physician.

This informational memorandum is an attempt to respond to such questions while presenting more general information about the licensure and certification of Physicians' Assistants.

The presence of the PA in the health services system is becoming increasingly apparent. This is a very positive use of allied health personnel and seems to be gaining broad support. The MSA Central Office supports the utilization of the PA and other physician extenders, and urges State agencies to

foster this growth by providing for and encouraging the use of PA's in the Medical Assistance program.

INQUIRIES TO: SRS Regional Commissioners

Commissioner
Medical Services
Administration

Attachment

PHYSICIANS' ASSISTANTS

Background

Among recent developments designed to relieve the acute shortages of physicians has been the emergence of physician extenders for whom training programs and employment opportunities are proliferating. Today there are more than 200 occupations concerned with patient care, community health, and environmental health that fall within the conceptual framework of allied health. One of the fast emerging concepts in the category of medical personnel is that of physician assistant (PA).

The American Medical Association has recommended use of the following working definition of the term "physician's assistant."

> "The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

Further, AMA states that the mission of a physician's assistant is to perform under the direction and supervision of a licensed physician, selected diagnostic and therapeutic tasks, thus permitting the physician to extend his services to a greater population base through the more efficient use of his knowledge, skills, and abilities. The physician's assistant does not supplant the doctor in the sphere of the decision making

required to establish a diagnosis and plan therapy, but will assist in gathering data necessary to achieve those tasks.

To date, it is estimated that approximately 200 educational programs for the training of physician's assistants are in development or operation. The variety of names used to identify graduates of such programs partially illustrates the diverse nature of the emerging educational programs. Examples include: Clinical Associate, MEDEX, Child Health Associate, Physician's Assistant, Medical Services Assistant, Physician's Associate, and Flexner (surgical assistant).

A series of specially designed projects is being carried out by the National Center for Health Services Research and

Development to develop types of physician extender manpower which can be used in new delivery modes including a uniform evaluation by NCHSRD of the effectiveness of various PA projects, and Center-sponsored demonstrations involving the use of other paraprofessionals such as nurse practitioners. Examples include: School Nurse Practitioner, Pediatric Nurse Practitioner, Nurse Midwife, Dental Auxiliary, PRIMEX, Nurse Clinician, and Family Nurse Practitioner.

Certification and Licensure

Many State legislatures are currently wrestling with the problem of how legally to accommodate the physician extender within the health care system. More than 30 States have enacted or proposed legislation to regulate the activities of the

physician's assistant. Most of the legislative proposals fall into two basic categories, both of which vest authority in the State Board of Medical Examiners, or similar State agency, to regulate the physician assistant or classes of nonlicensed allied health personnel trained to perform services in a dependent relationship to physician.

1. One mechanism provides an exception to the State's Medical Practice Act that codifies the physician's legal right to delegate routine patient-care functions to allied health personnel. The following States have enacted such exceptions: Arizona, Arkansas, Colorado, Connecticut, Delaware, Florida, Kansas, Oklahoma and Utah.

2. In the following States, legislation has been enacted to authorize the

State Board of Medical Examiners to approve training programs for the physician's assistant, certify graduates and approve a physician's use of no more than two graduates of such programs: California, Indiana, Iowa, Florida, Kansas, New Hampshire, New York, Oregon, and Washington. In the following States, comparable legislative proposals are or were pending in 1971: Alabama, Alaska, Illinois, Maryland, Michigan, Minnesota, Nebraska, North Carolina, Ohio, Pennsylvania, Tennessee, West Virginia and Wisconsin.

The AMA Council on Health Manpower is on record as preferring certification to licensure for the emerging health occupations. The Council argues that the PA's are the subject of attention and discussion disproportionate to their

relative impact upon the provision of health services with no one able to say what the impact of the PA's on the health delivery system may be in the future.

In the fall of 1970, both the AMA and the AHA issued statements recommending a moratorium on the licensure of additional health occupations and are currently collaborating in establishing a National Commission for the study of licensure for the allied health occupations. The moratorium, however, applies primarily to licensure and does not preclude certifying activities on the part of either of the two sponsoring organizations.

Recently in a report to Congress on the subject of licensure, Secretary Richardson recommended a two year moratorium on the licensure of additional

health occupations.

The American Medical Association has given a go-ahead on a mechanism for national certification of physician's assistants. The AMA blueprint for carrying out the certification program calls for a national standardized examination as the basis for evaluating the competency of individuals to function as physician's assistants. At AMA committee hearings State delegations testified that separate fee schedules should not be established for services performed by physician's assistants and that physicians alone should be responsible for billing procedures and payment to their assistants without any third-party involvement.

The AMA makes the following arguments for the need for some form of a national

program of certification of physician's assistants:

1. Programs for the training of physician support personnel under the rubric of "Physician's assistants" are springing up everywhere. Few programs are alike, and they range anywhere from twelve weeks to five years in duration. Programs will continue to vary significantly in both curriculum content and pre-requisites for admission. Certification is needed as an important complement to accreditation since a substantial number of qualified candidates at least at the outset will not be graduates of approved programs.

2. HEW has helped fund the maintenance and expansion of existing P.A. programs. The Federal Government is planning to increase its funding for such

training.

3. There is presently no uniform mechanism for evaluating the individual physician's assistant's competency to perform on the job.

4. The licensing of additional health care occupations tends to fractionalize the provision of health services. Licensure for new or emerging health occupations would be particularly ill-advised at this point in view of the developmental nature of their service roles.

Reimbursement

In general, physician's assistants consider themselves dependent practitioners, and are so considered by the 11 State laws permitting their use as well as the 20 proposed acts now pending. While some nursing groups favor the possibil-

ity of independent fee-for-service nursing practice, the almost universal view is not of increased private fee-for-service but organizational and distributional arrangements using a variety of health workers under the effective control and supervision of medical authority. Thus, this issue concerning physician's assistants is not one of independent practice, but of the way in which a physician or group practice meet its patient care responsibility; for example, how the services of a physician's assistant in a "satellite office" are monitored and reviewed.

Current Status Under Medicare

Under the Medicare law, the basic provision for coverage of paramedical services on a reasonable charge basis under Part B of title XVIII is as services

furnished "incident to a physician's professional services," as set out in Section 1861(s)(2)(A) of the act and elaborated in Section 6103 of the Part B Intermediary Manual. The incident-to provision permits coverage of the usual services of nurses and other assistants that are commonly furnished in physicians' immediate personal supervision, by his employees, and if the charges for the services are included in the physician's bill. Services provided only under the general or remote supervision of physicians are not covered. Thus, some of the services often suggested as duties of the physician's assistant are not covered Part B of Medicare; if a patient is seen only by a physician's assistant during a visit to an office

no charge may be paid by Medicare for the visit. As stated in Section 6103B of the Part B Intermediary Manual, however, the physician himself:

> "...might render a personal identifiable 'physician's service' which is covered even though payment could not be made for the separate, independent service rendered by the physician's assistant. For example, an office visit charge by the physician for a visit in which non-covered services were rendered by a physician's assistant may be reimbursed if the physician himself sees the patient at the time of the visit and at that time also makes an independent evaluation of the

patient's condition and of the course of treatment initiated or recommended by the physician's assistant."

For example, if the physician's assistant interviews the patient and takes a blood pressure, and the results are turned over to the physician to use to review and complete the examination, a charge could be paid for the total service performed. But, if, as noted above, the physician does not himself render sufficient service to constitute a covered visit, no payment may be made for the visit.

Under Medicare, when physician extenders and/or nurse practitioners are employed by a hospital the services would be covered as inpatient hospital services and reimbursed on a reasonable cost

basis. Likewise payment could be made under Part B on a cost basis for physician extender and/or nurse practitioner services furnished by such hospital to an out-patient. In extended care facilities, the physician's assistant or nurse practitioner may perform various technical services now covered when performed by personnel with other job titles.

There is no specific provision in the law for coverage of the type of services provided by physician's assistants and/or nurse practitioners to patients entitled to home health benefits.

Thus, it is evident that there are many problems in reimbursement of physician assistants under Medicare.

Current Status Under Medicaid: In contrast to Medicare, there are no statu-

tory or regulatory barriers for services of physicians' assistants under Medicaid.

As with Medicare, when physician extenders and/or nurse practitioners are employed by a hospital the services would be covered as inpatient hospital services and reimbursed on a reasonable cost basis.

The services performed by physician extenders and/or nurse practitioners employed by a physician, whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere would be covered for reimbursement provided that such services are provided under the personal supervision of a physician. Specifically, Medicaid regulations, "Amount, Duration and Scope of Medical Assistance," 45

CFR 249.10, define physicians' services as:

> "(5)'Physicians' services,' whether furnished in the office, the patient's home, a hospital, a skilled nursing home or elsewhere. 'Physicians' services' are those services provided within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."

Thus, there should be no problem concerning the reimbursement or billing of physicians' services when such reimbursement includes provision for the salary costs of physician extender

staff members.

The critical matter concerns the closeness of supervision which a physician must exercise over physician extenders. The regulation speaks of "personal supervision", but does not define further the context of such supervision. The Federal regulation permits each State to establish the degree of personal supervision which physicians must exercise. It is expected that such decisions will consider the need of rural communities for medical services, the distance from and availability of physicians vis-a-vis such areas, the use of electronic monitoring equipment between offices, the duties and functions for which physicians' assistants are responsible in the particular State, and the stage of development of State

licensure or certification for such occupations.

[USDHEW]

October 5, 1978

Our Reference: GC:RA:II:SJL

William Steibel, DDS
Deputy Commissioner
Division of Medical Assistance
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Mr. Steibel:

I am writing with reference to New York State's policy concerning reimbursement of social workers who render psychiatric services under the direct supervision of a physician to medicaid patients. It has come to our attention that Westchester County is refusing to provide reimbursement to physicians for care rendered by social workers under their di-

rect personal supervision. (See attached letter) The County has specifically stated that social workers may not be reimbursed directly and that "furthermore the fact that they may be providing services under the supervision of a private psychiatrist or psychologist does not enable that psychiatrist or psychologist to bill under his name for service they provide."

Although it is true that social workers cannot be directly reimbursed as individual providers under the New York State Medicaid plan, the quoted statement concerning reimbursement to a private physician for care rendered by social workers under his supervision is incorrect. As you know, physician services are required services under Medicaid. These services are defined at 42 C.F.R.

§449.10(b)(5) as "those services provided within the scope of practice of his profession as defined by State law, by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." (Emphasis supplied). Your state plan provides for physician services as defined in 42 C.F.R. §449.10(b)(5). Accordingly, you must reimburse for physician's services that are rendered under a licensed physician's supervision. Private physicians, therefore, may, indeed, be reimbursed under Medicaid for care rendered under their personal supervision even if the care is rendered by a social worker.

SLeiwant:maa

cc: Howard A. Sieven, Esq.

The Department is concerned that medicaid reimbursement is being denied physicians who have personally supervised care rendered to psychiatric patients by social workers. In at least one case that has been brought to our attention, reimbursement is being denied a psychiatrist who personally supervised social workers in treating psychiatric patients. Denial of reimbursement in that case is a violation of your state plan and Federal Medicaid requirements. We would appreciate it, therefore, if you would insure that reimbursement is not denied in cases where physcians' services were delivered under the personal supervision of a physician. Specifically, in the case of Dr. Edward Gordon, a psychiatrist in Westchester County, it appears that federal law has not been followed. It would

be appreciated if someone from your staff could contact the undersigned at 212-264-2857 concerning this matter so that some resolution may be achieved.

Sincerely yours,

Borge Varmer

Regional Attorney

By:_____

Sherry J. Leiwant

Assistant Regional Attorney

SLeiwant:maa

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

Mr. Dean J. Higgins
Assistance General Counsel [SIC]
Bureau of Medical Fraud & Abuse [SIC]
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

[11-02-78]

Dear Mr. Higgins:

We are writing in response to your October 6, 1978 letter to Mr. Theodore DeSantis which requests clarification of his earlier letter to Dr. Edward Gordon concerning Medicaid reimbursement for services rendered by social workers employed and supervised by psychiatrists.

The letter to Dr. Gordon is essentially a restatement of the policy interpreta-

tion provided to Dr. Steibel in a letter from this office dated May 17, 1978. The definition of physician services in section 42CFR 440.50 (formerly 42CFR 449.10 (b)(5)) encompasses those services provided "within the scope of practice of medicine or osteopathy as defined by State law," whether those services are performed "by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy" (underlining added). This statement has been interpreted to include the services of professionals employed by physicians, such as social workers, nurses, therapists, etc. The services of these professionals are covered for Medicaid reimbursement under "physician services" provided they are rendered under the personal supervision

of a licensed physician.

Contrary to statements in your letter, the above does not imply that allied health professionals may practice medicine, but rather permits the physician to be reimbursed as part of his fee for the services of those individuals in his employ and working under his supervision, performing services within the scope of their own professional disciplines. It is beyond the intent of our letter to determine whether the actual billing codes used currently or in the past by psychiatrists billing for services performed by social workers in their employ are appropriate; our intent is to clarify that such services are reimbursable under Medicaid with Federal Financial Participation available. We are distinguishing between the

reimbursement of social workers as independent providers, which is clearly excluded by The New York State Plan, and the reimbursement of the psychiatrist for services rendered by such individuals employed and supervised by him, which is clearly provided for within the scope of "physician services."

In response to your closing paragraph, our Counsel is in concurrence with the above federal policy interpretation. We hope we have answered your questions with regard to our previous letter.

Sincerely,

Tecla Kern
Branch Chief State
Operations

cc: Blum
Steibel

bcc: A. O'Leary

S. Budoff

T. Kern

K. Alexander:ls 11/02/78

DEPARTMENT OF HEALTH, EDUCATION
AND WELFARE

Refer to: 0:9

Mrs. Barbara Blum, Commissioner
New York State Department
of Social Services
Ten Eyck Building
40 North Pearl Street
Albany, New York 12243

(2-07-79)

Dear Commissioner Blum:

In the last 8 months we have exchanged correspondence with Dr. Steibel and Mr. Dean J. Higgins on the issue of Medicaid reimbursement for services rendered by social workers employed and supervised by psychiatrists to provide counseling and therapy as part of a plan of treatment.

Since our initial letter to the Division

of Medical Assistance on this issue dated May 17, 1978, we have maintained the same position. Dr. Steibel has taken issue with our position and, as he requested at a recent meeting with Mr. Richard Heim, we submitted the matter to our central office for their review. In this letter we hope to clarify any remaining questions on federal policy concerning payment to psychiatrists who utilize psychiatric social workers.

"Physicians' services" are defined in 42CFR 440.50 as services provided "within the scope of practice of medicine or osteopathy as defined by State law; by or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." (emphasis added). As we stated previously this regulation makes FFP available not

only for services provided by a physician licensed and practicing according to State law, but also makes FFP available to the physician for services of professionals and paraprofessionals employed by him and functioning under his supervision. In the latter instance the physician professionally accepts responsibility for the work of the nurse, social worker or other individual under his supervision. Both counsel here in our Regional Office as well as our central office staff have concurred that the services of the employed professional or paraprofessional fall within the category of "physicians' services" and are reimbursable as such.

Mr. Higgins in his letter of October 6, 1978 misinterpreted our statements to imply that this policy would enable a

social worker to practice medicine. This is clearly not the intention of the regulation. It is instead intended to permit the psychiatrist to be reimbursed as part of his fee for a social worker in his employ and working under his supervision providing services within the scope of the State licensure for social workers. Our central office pointed out that "...it is not the (State) agency's perogative to delineate whom a physician may employ to provide services under his supervision. This is delineated by those State laws which define the parameters within which any physician may practice." (parenthesis added).

Mr. Higgins indicated that a psychiatrist has billed and received payment under NYS's Medicaid Program for services rendered by social workers employed by

him under the billing code for psychotherapy. The question here is whether there is another more appropriate billing code available for use by psychiatrists submitting claims for patient treatment or counseling provided by social workers, or psychologists or other counselors under their supervision. We are aware that there is a billing code set up for psychiatric clinic sessions provided by personnel under the supervision of a psychiatrist. Perhaps you will want to consider establishing such a separate billing code for use by private psychiatrists when billing for therapy similarly provided as individual or group counseling by social workers, psychologists, or other therapists.

There was a second question raised by the State agency at the meeting with Richard

Heim, concerning dollar limitations on psychiatrist services. Our Central Office did agree that States may set continuing authorization requirements on services which may be determined financially or time wise. They cautioned, however, that any system of prior authorization must be "objective, efficient, protective of the right of concerned parties, and not administered in an arbitrary manner." Further, prior authorization as a method of safeguarding against unnecessary utilization, especially for items of very expensive care, must be distinguished from "limitations" on services since States are not permitted to set limits on the amount, duration, or scope of a required service to an otherwise eligible recipient, solely because of diagnosis, type of illness,

or condition (42CFR 440.230). Physicians's services generally must be available to the mentally ill as they are provided to other eligible recipients. We suggest that you review MSA-PPG-12, the Program Regulation Guide for Prior Authorization which sets forth limitations and criteria for systems of prior authorization.

We will be pleased to discuss these issues further if you have additional questions.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

cc: W. Steibel, DDS

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

Refer to: 0:9

March 21, 1979

Mrs. Barbara Blum, Commissioner
New York State Department
of Social Services
Ten Eyck Building
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

We are writing in follow-up to our letter dated February 7, 1979, concerning Medicaid reimbursement for services rendered by social workers employed and supervised by psychiatrists.

We are anxious to resolve this issue since, as you know, this matter has been

outstanding for some time. Further, we believe that the Regional Office has provided you with adequate clarification of the issue, and we have obtained concurrence from both our Central Office and our legal counsel. At this time we would like to know what actions you have taken or planned to bring State practice into conformance with Federal requirements. We would also like to remind you that our staff is available to meet with you on this matter if you have further problems.

Thank you for your cooperation.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

A 140.

July 9, 1979

Refer to: 0:9

Ms. Barbara Blum, Commissioner
New York State Department
of Social Services
Ten Eyck Building
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

This letter is in follow-up to all our previous correspondence concerning Medicaid reimbursement for services rendered by social workers employed and supervised by psychiatrists.

Our previous letter of February 7, 1979, which set forth the Regional Office position, as well as our follow-up letter of March 21, 1979, are enclosed. We feel

we have given the State considerable time to review State policy in this area and to revise those policies which are not in conformance with Federal requirements. We therefore ask your cooperation in advising us what actions the State agency has planned in order to resolve this issue.

We look forward to an expeditious reply on this matter.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

Enclosure

cc: D. Glasel
M. Berkowitz

bcc: P. McHugh (w/enc.)
A. O'Leary

bcc: S. Budoff

T. Kern

C. Nisnewitz

K. Alexander:ls 7/6/79

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

Control #870
Due Date 7/25

July 30, 1979

Mrs. Barbara Blum, Commissioner
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

We are writing in regard to Department of Health regulations which were promulgated on 2/26/79 concerning Outpatient Psychiatric Care Provided By A Private Practicing Physician (Subchapter K, Chapter II, Title 10 (Health) Sections 85.28 through 85.31.) A copy of these

regulations were provided to the HEW Regional Attorney by Dr. Gordon, a private practicing psychiatrist, and we have enclosed a copy of our response to his letter.

As you can see from our letter to Dr. Gordon, we believe that an efficient system of prior approval for selected medical services represents a valid means of State utilization control. We do, however, have some questions regarding these regulations and we would appreciate some clarification from you.

1) Section 85.28(C) states that to be covered under Medicaid, outpatient psychiatric care rendered by a private practicing physician must be provided by a qualified psychiatrist. We would like to point out that the

Federal Medicaid definition of physician services is much broader than this, and includes both services by or under the personal supervision of a physician. We hope that this regulation does not attempt to place a limitation on the provision of psychiatric services which is not reflected in the State plan.

2) The regulations state that a treatment plan must be submitted prior to the 15th visit in a six month period, and based upon the determination of the local professional director, dates for subsequent treatment plan submission and review will be set. What is the timeframe for a determination on the treatment plan by the local professional director? If a request

for prior approval has not been acted on within a specified period of time, is it automatically approved? Central to any system of prior approval should be the concern that the process not unduly delay the rendition of needed services.

We would appreciate your providing us with an expeditious reply. Thank you for your continued cooperation.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

Enclosure

bcc: Leiwant
O'Leary
Budoff
Kern

bcc: Nisnewitx

Alexander:sg 7/26/79

DEPARTMENT OF HEALTH, EDUCATION
AND WELFARE

Control #937
Due Date 9/6
Refer to: 0:9
October 4, 1979

Mrs. Barbara Blum, Commissioner
New York State Department of
Social Services
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

We have received your letter of August 17, 1979 concerning your Department's policy regarding "social workers employed and supervised by psychiatrists."

Despite the arguments presented by your

Office of Legal Affairs, the Federal position on this question remains the same as was presented to you in our earlier letters. The interpretation which we communicated to you was reached with the concurrence of our Central Office and with our Office of General Counsel.

In your letter you indicated that your office may be pursuing the development of new regulations and you asked for information concerning Medicaid coverage of social workers in other States. Although we do not have ready access to State plans in other Regions, the definition of "physicians' services" as services rendered "by or under the personal supervision" of a physician, is contained in Federal regulations and therefore applies to programs in effect

in all jurisdictions. We will, however, query our Central Office to determine if they have additional information on specific coverage of social workers in any of the other States.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

bcc: O'Leary
Budoff
Kern
Alexander: sg 9/25/79

A 151.

(USDHEW)

Refer to: 0:9

Control # 219

Due Date 1/30/80

February 01, 1980

Mrs. Barbara Blum, Commissioner
New York State Department of
Social Services
Ten Eyck Building
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

We are writing in further regard to our letter of 10/4/79 (prompted by your letter of 8/17/79) concerning social workers employed and supervised by psychiatrists in independent practice.

In our letter we explained that Federal policy concerning Medicaid coverage of social workers rendering services under conditions stated remains unchanged. A review of past policy interpretations which we have advised you of in recent correspondence has not altered the Federal position. We are again requesting that you notify us of what steps have taken to bring State practice into conformance with Federal requirements. Related to this matter, we note we have never received a response from you office to our 7/30/79 letter asking for clarification on Department of Health regulations which were promulgated on 2/26/79 concerning Outpatient Care Provided By A Private Practicing Physician (Subchapter K, Chapter II, Title 10 (Health) Sections 85.28 through 85.31).

We look forward to hearing from you on these matters.

Sincerely,

Arthur J. O'Leary
Regional Medicaid
Director

bcc: Annette Blum
O'Leary
Kern
OPO
Alexander: sg 2/1/80

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE

Refer to: 0:10
Control #327
Due Date: 3/19/80

June 16, 1980

Mrs. Barbara Blum, Commissioner
New York State Department of
Social Services
Ten Eyck Building
40 North Pearl Street
Albany, New York 12243

Dear Commissioner Blum:

This is in further reference to your letter of February 29, 1980, concerning certified social workers providing services under the direction of a psychiatrist.

We were pleased to learn that psychiatrists will be reimbursed for the services of certified social workers under their direction. However, the State cannot limit the category of staff who may be supervised by a psychiatrist or other physician. The exclusion of other professionals and paraprofessionals (i.e. - psychologists, therapists) violates the definition of physician services contained in 42 CFR 440.50.

Would you please advise us of the steps you have taken to conform with the Federal regulations.

In addition, could you please inform us of the status of the Department of Health regulations concerning Outpatient Care Provided By A Private Practicing Physician (Subchapter K, Chapter II, Title

10 (Health) Sections 85.28 through 85.31).

We look forward to hearing from you on these matters.

Sincerely,

Arthur O'Leary
Regional Medicaid
Director

DEPARTMENT OF HEALTH, EDUCATION,
AND WELFARE
REGION II
FEDERAL BUILDING
26 FEDERAL PLAZA
NEW YORK, NEW YORK 10007

July 8, 1980

OFFICE OF THE
GENERAL COUNSEL

John S. Martin, Jr.
United States Attorney
Southern District of New York
One St. Andrews Plaza
New York, New York 10007
Attention: Stephen Dvorkin
Special Assistant
U.S. Attorney

Dear Mr. Martin:

This letter is in response to the request of Judge Charles S. Haight, Jr. that the Department of Health and Human Services set forth its interpretation of 42 C.F.R. §440.50 and the provisions of the Social Security Act under which it was promulgated. Judge Haight has requested this interpretation in the context of a civil action in which Dr. Alvin Yapalater, a psychiatrist, contends that New York State and Westchester County officials administering the New York State Medicaid Program are violating 42 C.F.R. §440.50 by refusing to reimburse him for psychotherapeutic services provided by non-physicians working under his supervision.

It is this Department's position which has previously been communicated to New York State, that "physicians'' services"

under Medicaid program include services provided "...By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy." (emphasis supplied) Therefore, New York State may not properly refuse to reimburse a physician for services which are within the scope of practice of medicine or osteopathy as defined by State law and provided under his or her personal supervision.

Pursuant to the Medicaid provisions of the Social Security Act, physicians' services are required services, i.e., a State which participates in the Medicaid program must include coverage of physicians' services in its State Plan and provide reimbursement for such services. Sections 1902(a) 13 and 1905(a)(5) of the Social Security Act, 42 U.S.C. §§1396a(a)

(13) and 1396d(a)(5). The Secretary has promulgated the regulation at 42 C.F.R. §440.50 to define physicians' services.

That regulation provides:

> "Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided --
>
> (a) Within the scope of practice of medicine or osteopathy as defined by State law; and
>
> (b) By or under the personal of an individual licensed under State law to practice medicine or osteopathy.

In order for services to be reimbursable as physicians' services "within the meaning of this provision, the requirements of subsections (a) and (b) must be met. Therefore a service must be one within the State law definition of the scope of

practice of medicine or osteopathy and provided by or under the personal supervision of a licensed medical or osteopathic physician. Reimbursement may not be withheld solely because an otherwise reimbursable service is provided under the personal supervision of a physician rather than by him or her directly. The State may, of course, decline to reimburse a service if it is not within State law definition of the scope of practice of medicine or osteopathy or if it is provided without the actual personal supervision of a licensed physician. In addition, it is within the State's authority to set appropriate fees for reimbursement depending on the nature of the service rendered.

Copies of correspondence relating New York State's compliance with 42 C.F.R.

§440.50 are attached for your further information.

While this interpretation of federal Medicaid requirements is provided pursuant to Judge Haight's request, nothing herein should be interpreted as ruling upon the specifics of Dr. Yapalater's claims for reimbursement.

Very truly yours,

Frank V. Smith, III
Regional Attorney

By: _____

Annette H. Blum
Assistant Regional
Attorney

Enclosures

STATE OF NEW YORK
DEPARTMENT OF HEALTH OFFICE OF HEALTH
SYSTEMS MANAGEMENT
TOWER BUILDING * THE GOVERNOR NELSON A.
ROCKEFELLER EMPIRE STATE PLAZA * ALBANY,
N.Y. 12237

DAVID AXELROD, M.D. RICHARD A. BERMAN
COMMISSIONER DIRECTOR

October 19, 1979

Mr. Carl Letson
Senior Legislative Budget Analyst
NYS Assembly
Ways and Means Committee
State Capitol
Albany, New York

Dear Mr. Letson:

This is in reply to your letter of

October 15, 1979, in which you set forth a number of questions pertaining to proposed new section 85.32 of the Commissioner of Health's Administrative Rules and Regulations. Section 85.32 covers the subject of Medicaid reimbursement for social work services under the supervision of a psychiatrist in the course of private practice. I shall restate your questions, and then respond in the order presented, unless otherwise indicated.

1. What was the problem which resulted in the development of the proposed regulation?

Answer: Social work, standing alone, has never been a "covered service" in the New York Medical Assistance Program, although social work is allowed in the context of total inpatient hospi-

tal or residential health care facility service. Several psychiatrists attempted to bill Medicaid for social worker services to patients. In some counties, the local social services district allowed Medicaid reimbursement -- others did not. When this disparity was brought to the attention of the Department of Social Services, a decision was made to disallow the costs.

In other counties, social workers attempted to bill directly for their services in cases where the care was rendered under the supervision of a psychiatrist. These bills were denied.

Both situations were presented to HEW on a number of occasions. Finally, HEW ruled that physician services must be part of the Medicaid plan, and that such services include those elements of

care rendered by or under the supervision of a doctor. From the stated premise, HEW then concluded that social worker care under the supervision of a psychiatrist must be allowed.

2. What involvement did staff of the Senate have re the development of this regulation?

Answer: Senate staff received complaints about our policy from constiuents which were forwarded to us. This matter was under study for more than a year before we received any legislative inquiries.

3. Why was the proposed regulation published in the August 15, 1979 NYS Register and the Legislature not officially notified of the proposed amendment pursuant to Section 101-a of the Executive Law until September 19, 1979?

Answer: An unintentional oversight.

4. Were any public hearings scheduled or are any public hearings planned re this proposed regulations?

Answer: No.

5. What is the present fiscal impact (i.e. increased Medicaid costs to State and Local governmental units) of this proposed regulation and what is the potential future fiscal impact as this funding mechanism is accessed by psychiatrists who may hire social workers?

Answer: The immediate fiscal impact is difficult to estimate for a number of reasons. Precise cost data on the component parts of physician care in the Medicaid program are not readily available. The decentralized local bil-

ling and paying process, gradually being replaced by a centralized and automated process (MMIS), is the chief reason for lack of adequate data.

However, we do know that the private practice of medicine, in total, accounts for about 5% of the total annual Medicaid pay out. (Less than $130M) Payments to private psychiatrists, not organized clinics, account for no more than 5% of the total M.D. pay out (About $6M). The add on effect of presently disallowed social worker claims, for services under the supervision of psychiatrists is, judging by the volume of original complaints, not significant. Based on discussions with practioners, we doubt that many private practicing psychiatrists in the Medicaid program use social workers, and even those who do,

call upon their services for only a fraction of total case load.

Further, some of the services covered by section 85.32 are already being reimbursed in some districts, because of the confused status of the problem. In addition, the proposed fee (see answer to Question 7, below) will produce some savings over current billings in those cases currently claiming at the full psychiatrist fee level.

The potential future impact will be discussed as part of the answer to Question 15, below.

6. What is the statutory authority to allow for the billing of services by a psychiatrist for the activities of a social worker?

Answer: Title 19 of the Social Security Act (Medicaid) specifies that

physician services must be part of each state plan (Sections 1902 (a)(13); 1905 (a)). 42 Code of Federal Regulations 440.50 requires that services under the supervision of a physician be included. Proposed section 85.32 sets forth our state conditions.

7. What would be the rate of payment to psychiatrists for services provided by social workers?

Answer: See answer to Question 17, below.

8. Will a psychiatrist be able to claim overhead costs for supervision above the social workers service fee schedule?

Answer: No.

9. The limits of the term "supervision" by a psychiatrist are only defined in the regulation as being "regu-

lar communication and consultation" between the social worker and the psychiatrist. A similar action taken in Chapter 893 of the Laws of 1977 (allowing M.D. reimbursement of professional nurses) sets out certain specific requirements for such a relationship. What are DOH's intentions here?

Answer: Our experience in developing various kinds of medical standards indicates that attempts to dictate details which affect the actual practice of medicine will be immediately challenged. In fact, just such a case is still pending on the matter of general standards for psychiatry. It is our intention to permit usual and customary supervision to prevail, subject to our four social worker limit. If studies indicate the necessity for more specifici-

ty, we will move to modify, keeping in mind anticipated objections. If the legislature itself chooses to enact conditions, such as those you cite in Chapter 893 of the Laws of 1977, we will, of course, carry them out.

10. Must the social worker be employed by or simply contracted by the psychiatrist? If the latter, will this foster an arrangement where contracting is common?

Answer: Our proposed regulations permit any type of arrangement for compensation between M.D. and social worker. Supervision is the key. We doubt that contracting will become common.

11. Is such employment or contracting common practice at the present time? How was the four maximum social worker limit arrived at?

Answer: As pointed out in our answer to Question 5 above, we doubt that many of the private practicing Medicaid enrolled psychiatrists use the services of social workers. The maximum of four social workers is our effort to allow a reasonable degree of delegation to certified social workers, but to preclude so large a practice that supervision is patently impossible.

12. Does such an arrangement violate the professional conduct in education law which concerns fee splitting? (21.1B, 3 & 4 of Ed. Dept's regulations.)

Answer: No. There is no New York Medicaid right of social workers to bill, so there is no social worker fee that can be split.

13. What impact does this proposed regulation have on efforts of other

human service professionals to receive funding coverage under Medicaid (e.g., school psychologists, registered nurse therapists, occupational and physical therapists)?

Answer: On the basis of the HEW opinion, any services customarily within the scope of the practice of medicine could be reimbursed to the doctor if such services are rendered by appropriately trained and licensed staff under the M.D.'s supervision.

14. What limitations have been placed on the type of billable services that may be performed by a social worker under a psychiatrist's supervision.

Answer: See answer to Question 17, below.

15. How does the proposed regulation limit the potential for Medicaid

funding "ripoffs" by high volume operations?

Answer: The presence of high volume Medicaid facilities does not automatically create abuse. However, by limiting the number of social workers who may be employed by a psychiatrist, as discussed in answer to Question 11 above, the potential for "Medicaid mill" situations is limited. Social workers so engaged will be required to enroll in the Medicaid Program. Under the Medicaid Management Information System (MMIS), each enrolling individual will be assigned a unique MMIS Provider Indentification Number. This number will permit us to monitor activities through the Surveillance and Utilization Review (SUR) subsystem of MMIS, and to identify instances in which an indivi-

dual may seek employment with more than one psychiatrist. MMIS enrollment also involves licensure verfication and enforcement of the rule limiting reimbursement to four social workers associated with a single psychiatrist.

The services of social workers supervised by psychiatrists are viewed, in Medicaid terms, as integral components of the comprehensive treatment plan required of the private practicing psychiatrist under Section 85.29(a) of the Commissioner's Administrative Rules and Regulations. Specifically, if a patient requires more than a total of fifteen services from either a psychiatrist must seek approval from the Medicaid local professional director of a detailed treatment plan, including diagnosis, progress achieved, future case management,

and prognosis. Failure to submit an acceptable plan of care results in disallowance of further Medicaid reimbursement to the psychiatrist and, therefore, to the social worker. Treatment plans are time limited, and amendment or extension of treatment plans requires the approval of the Medicaid local professional director. Ongoing treatment plans, including proposed services of social workers, are evaluated at a minimum of once every three months.

General patterns of care demonstrated by Medicaid participating social workers will be evaluated by the MMIS SUR subsystem through the use of "exception reports" which focus attention upon unusual patterns or intensities in patient care. If unacceptable practices are discovered, removal from the Medicaid

program, and in extreme cases, Fraud and Abuse referral are available remedies.

As MMIS and its subsystems become statewide in applicability more and more detailed, complete, accurate and prompt data will be available. MMIS is already in place in New York City, where a large concentration of Medicaid recipients exists. Targeted reviews of suspected abusers is possible, and is in place in some cases at this time.

16. What limits have been developed re the billing of Medicaid by psychiatrists (including facility directors) employed by the Department of Mental Hygiene for services provided during the course of their "private" practices?

Answer: None. We assume that OMH is capable of placing proper limits on the outside employment of its staff.

A licensed M.D. is entitled to enroll in the Medicaid program, with or without social workers as adjuncts. However, we could obtain from OMH, or any other agency, a list of M.D.'s prohibited from outside employment. Such a list could become part of the enrollment review process. If such a doctor's name appeared for enrollment, it would be disallowed.

17. What are the respective responsibilities of OHSM and DSS re the adoption of maximum reimbursement schedules for social work services or amending existing schedules?

Answer: Adoption of a maximum State reimbursement schedule will require amendment to the existing State maximum reimbursable fee schedule for physician services (State Medical Fee

schedule), psychiatric section. An amendment is being developed by the Office of Health Systems Management to include interim fees for payment to qualified psychiatrists for social work services provided under their direct supervision by qualified social workers.

The new interim fees will be developed upon completion of an analysis of existing physician fee codes and service procedures, and will be a fraction of the current M.D. psychotherapy fee. The schedule will also contain language describing the services covered by the fee.

The interim fees for social work services will be promulgated as an addendum to the State Medical Fee Schedule, Section I, Item 370, Fee and Rate Schedules, of the State Medical Handbook. The fees will also be included in the

MMIS Physician's Provider Manual to be used in MMIS counties. The State Department of Social Services will also issue notice of these interim fees to each local social services district via an Administrative Directive.

The experience in use of these interim fees will be closely monitored by reports obtained from MMIS and State Social Services (from non-MMIS counties), so that an analysis may be made by OHSM for use in recommending permanent fees for approval by the State Director of the Budget.

I believe all your questions have been addressed, hopefully to your satisfaction. The answers to Questions 1 and 2 state the process leading to the present proposal. The decision to add

Section 85.32 was discussed with the Division of the Budget and the Executive Chamber during the policy stage of development, but not in detailed terms.

All other steps preliminary to final filing with the Secretary of State have been completed. We are anxious to put Section 85.32 in place. Please advise as soon as possible if our response requires any amplification.

Sincerely yours,

Donald B. Davidoff
Assistant Director
Health and Medical
Care Standards Group

cc: Mr. Berman
Mr. Rodat
Dr. McGarvey
Mr. Liddle

cc: Mr. Starks

Mr. Baehm

Dr. Guy

Ms. Bass

Mr. Jasinski

Mr. Hartman

Mr. Smith

STATE OF NEW YORK
DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT
TOWER BUILDING * THE GOVERNOR NELSON A. ROCKEFELLER EMPIRE STATE PLAZA * ALBANY, N.Y. 12237
DAVID AXELROD, M.D. COMMISSIONER
RICHARD A. BERMAN DIRECTOR

October 24, 1979

Mr. Carl Letson
Sr. Legislative Budget Analyst
NYS Assembly
Ways and Means Committee
State Capitol
Albany, New York

Dear Mr. Letson:

As requested in your letter of October 22, 1979, set forth below are our responses to your additional ques-

tions concerning promulgation of section 85.32 of the Commissioner of Health's Administrative Rules and Regulations pertaining to reimbursement for services rendered by social workers under the supervision of psychiatrists.

1. We would like to receive copies of the following documents: Section 85.29 of the Department's Rules and Regulations; 42 Code of Federal Regulations 440.50; the HEW ruling regarding inclusion of physician services in the Medicaid plan and the HEW conclusion that social worker care under the supervision of a psychiatrist must be allowed; the decision made by the Department of Social Services to disallow medicaid reimbursement; a copy of the revised Section 85.32, setting a limit of four social workers to each psychiatrist.

Answer: Enclosed is a copy of section 85.29. Enclosed is a copy of 42 CFR 440.50. Enclosed is a copy of the HEW letter to DSS. We have no copy of the original decision by DSS to disallow. Enclosed is a copy of revised section 85.32 containing the specific reference to the four social worker limitation.

2. In which counties did the local social services district allow reimbursement, and in which counties was reimbursement not allowed?

Answer: We do not have the specific information on the question of which counties specifically allowed or disallowed reimbursement.

3. Will the August 15th date of the State Register announcement or the September 19th date of legislative notification be used to ensure techni-

cal compliance with the 60 day federal requirement?

Answer: It has been determined by Office of Counsel for both Department of Social Services and Health Systems Management that the 60 day Federal notice requirement is not applicable in the instant situation because the fiscal impact will not exceed the minimum requirement of the new Federal regulation.

4. Have you developed a projection of the number of social workers likely to become involved in this arrangement based on factors other than volume of complaints?

Answer: No.

5. How would psychiatrists reimburse social workers for services--will a contractual mechanism be in place

to establish an accountable flow of funds?

Answer: As we attempted to state in our earlier letter to you on a similar question, we will have no direct interest in the manner in which social workers are reimbursed by psychiatrists. In some cases, the social workers will actually be employees of the private practicing psychiatrist. In other cases, they will be more in the nature of independent contractors, subject always of course to the direct supervision of the psychiatrists. Our control to avoid Medicaid abuse will be by the means of MMIS and SUR analysis of volume of claims by psychiatrists, plus a matching review of social workers to determine where they are working. More specifically in response to your ques-

tion, we will not require that a contractual mechanism be in place to establish an accountable flow of funds. We will be dealing with psychiatrist only, and not with social workers.

6. Although social workers will not be able to bill directly, psychiatrists will. When the psychiatrist reimburses the social worker, he is essentially splitting a fee. Does this practice violate the professional conduct in education law concerning fee splitting?

Answer: No. In fact, if the social worker is an employee, there is no fee splitting, legal or otherwise. If a contractual arrangement exists, that technical type of fee splitting is not prohibited. (Education Law section 6509-a; section 29.1(b)(4) of

the Regents' Rules and Regulations). I discussed this matter with Mr. Burgess in Office of Counsel of the Education Department.

7. If a social worker cannot charge directly can he/she still enroll in the MMIS system?

Answer: As indicated in our answer to number five above, and as we stated in our first answer on a similar question, we will require all such social workers to enroll in the MMIS system, not because they will be direct vendors, but because it provides us with the appropriate double check we need. By this means, we will be able to review psychiatrists' bills against the matching enrolled list of social workers. Please refer to my more detailed answer in the first letter to you on this subject.

8. Do any statutes or regulations exist which prohibit Office of Health Systems Management employees from accessing the Medicaid program or otherwise regulate them?

Answer: I assume you are referring to any prohibition against Health Systems Management employees becoming direct or indirect suppliers of medical care under the Medicaid program. Public Officers Law section 74(2) provides that no employee of a State agency should have any interest or engage in any business or professional activity which is in substantial conflict with the proper discharge of his duties. This conflict of interest section has been interpreted to prohibit any of us in Health Systems Management from rendering services for consultation and claiming under Medicaid. In addition,

a broad statement on this subject is in our policy manual. There are no specific regulations, however.

9. Will the necessary amendment to the existing maximum reimburseable fee schedule require legislative action? If not, from where does the agency derive the power to adjust the schedule? Could you provide us with a timetable for such action and an interim fee breakdown? It would seem appropriate to defer final promulgation of this regulation until the analysis has been completed and a new fee schedule has been developed.

Answer: Amendments to the fee schedule to [sic]not require legislative action. All fee schedule matters are covered by the general authority in the Social Services law for the regulation and payment for services as part of the

Medicaid program. Interim fees are now ready for publication. We have completed our study coming from an economic and program point of view. The proposed interim fees are attached. It was always are [sic] intention, and in fact a program necessity, that the interim fees be made available simultaneously with promulgation of new section 85.32. However, final fees will not be promulgated and approved by the Director of the Budget until we have had some time to review the implications and experience which this new program change establish. [sic]

10. Could you provide us with the name of your contact in the Department of Social Services for development of the new fee schedule? In addition, we would like the name of your contact in HEW.

Answer: Our primary contact on all Medicaid matters in the Department of Social Services is with the Division of Medical Assistance currently headed by Mr. Robert Skerrett as Acting Deputy. We have no contact person in HEW.

11. Is it necessary to have the Division of the Budget approve interim fees?

Answer: No.

I trust our responses satisfactorily answers the questions you have posed. The 30 day filing provision under section 101-a of the Executive Law expired on October 19, 1979. We recognize, that by oversight, the filing process did not begin at the same time as did our filing under the provision of the Administrative Procedures Act. However, it is our responsibility to act now to file these

rules in view of the clear policy decision to make the services of social workers under the supervision of psychiatrists available to Medicaid recipients. Please let me know as soon as possible if there is further information you need.

Sincerely yours,

Donald B. Davidoff
Assistant Director
Health and Medical
Care Standards Group

Enclosures

bcc: Mr. Berman
Mr. Rodat
Dr. McGarvey
Mr. Liddle
Mr. Starks
Mr. Baehm
Mr. Guy

Ms. Bass

Mr. Jasinski

Mr. Hartman

Mr. Smith

MEDICAL SOCIETY OF PUTNAM COUNTY
38 Gleneida Avenue
Carmel, N.Y. 10512

October 9, 1978

Mr. John W. Sweeney,
Commissioner,
Putnam County Department
of Social Services
50 Main Street
Brewster, New York 10509

Dear Commissioner Sweeney,

Dr. Edward Gordon came before the Executive Committee of the Medical Society of Putnam County on October 4, 1978 to inform us of his difficulties with the Putnam County Department of Social Services. He presented documentation of the dispute which centers about his right to continue treating

Medicaid patients on the same basis as private or third party paying patients. Specifically, his use of a psychiatric social worker to provide therapeutic services, under his supervision, to certain patients, has been questioned.

Dr. Gordon presented copies of correspondence dating back to January 27, 1978 with the Putnam County Department of Social Services and a variety of other correspondence, notably an opinion by Theodore DeSantis, Supervisory Medicaid Specialist of the Department of Health, Education and Welfare, that:

> "physicians'services.....are those services provided..... by or under the personal supervision of an individual licensed under state law to practice medicine or osteopathy." Mr. De Santis continues: "The above means that the services performed by persons employed by a physician, such as social workers, psychologists, nurses,

> etc., are covered for Medicaid reimbursement provided that such services are under the personal supervision of the physician. The physician bills and receives Medicaid reimbursement in accordance with the established fee schedule."

Title XIX (Medicaid) requires that patients be given a free choice of providers and that they be given access to private practitioners. The Department of Social Services is restricting the use of social workers in the office of a private psychiatrist, all the while utilizing their services, on a less supervised basis, in the clinics which it operates. You must be aware of the fact that social workers are an essential part of the mental health team in the office of adult and child psychiatrists, mental health clinics, private and voluntary agencies and hospitals.

The Medical Society of Putnam County objects to the Putnam County Department of Social Services' restriction of private practice in violation of Title XIX, its attempts to impose a standard of practice of private psychiatrists which is in opposition to the standards of good medical practice, and in opposition to the standards by which the county operates its Mental Health Clinics.

There is no State Regulation restricting the degree to which a psychiatrist may supervise a social worker treating his patients in his office. The Medical Society of Putnam County objects to the Department of Social Services' attempts to arbitrarily impose a standard which is in opposition to Federal Regulations.

The Society supports Dr. Gordon in his resolve to treat patients in accordance with the best precepts of medical care, and to treat Medicaid patients on a par with private patients.

We hereby request that the Department of Social Services reverse its position, as we feel that its position is not in the best interests of patients receiving Medicaid services, and is also in violation of State and Federal Law.

We support Dr. Gordon in his resolve to resist this unwarranted intrusion into the private practice of medicine and stand ready to support him financially if, regrettably, he be forced into Federal and State courts to obtain compliance with the law.

Sincerely,

Charles Block, M.D.

President

Att.

42 USC § 1320a-2. Qualifications for health care personnel

(a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under Title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until December 31, 1981, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, <u>therapists</u>, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, <u>psychiatric technicians</u>,

or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technicians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

(b) If any individual has been determined, under the program established

pursuant to subsection (a) of this section, to be qualified to perform the duties and functions of any health care specialty, no person or provider utilizing the services of such individual to perform such duties and functions shall be denied payment, under subchapter XVIII of this chapter or under any State plan approved under subchapter XIX of this chapter, for any health care services provided by such person on the grounds that such individual is not qualified to perform such duties and functions.

[underlining supplied]

42 USC § 1396. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and

had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance.

42 USC §§ 1396a. State plans for medical assistance—Contents

(a) A State plan for medical assistance must—

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual

described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause A; and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by

the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in

clause (A) shall be equal in amount, duration, and scope: except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency

on behalf of such individuals), or provision for meeting part or all of the costs of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical

institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

42 USC §§ 1396a.

(a) A State plan for medical assistance must—

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

42 USC §§ 1396a.

(a) A State plan for medical assistance must—

(23) provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to pro-

vide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization;

42 USC § 1396a.

(a) A State plan for medical assistance must—

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and

to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

42 USC § 1395x

Physicians' services

(q) The term "physicians' services" means professional services performed by physicians, including surgery, consultation, and home, office, and institutional calls (but not including services described in subsection (b)(6) of this section).

Physician

(r) The term "physician" when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1301(a)(7) of this title).

42 USC § 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

R.S. § 1979.

42 CFR § 431.51 Free choice of providers.

(a) This sec. implements section 1902(a)(23) of the Act, which provides that recipients may obtain services from any qualified medicaid provider.

(b) A State plan (except in Puerto Rico, the Virgin Islands, and Guam) must provide that any recipient may obtain medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

(c) If the medicaid agency contracts on a prepayment basis with an organization that provides services additional to those offered under the State plan, the agency may restrict the provision of the additional services to

recipients who live in the area served by the organization and wish to obtain services from it.

(d) Paragraph (b) of this section does not prohibit the agency from--

(1) Establishing the fees it will pay providers for medicaid services; or

(2) Setting reasonable standards relating to the qualifications of providers.

42 CFR §§ 432.50 FFP: Staffing and training costs.

(a) Availability of FFP. FFP is available in expenditures for salary or other compensation, fringe benefits, travel, per diem, and training, at rates determined on the basis of the individual's position, as specified in paragraph (b) of this section.

(b) Rates of FFP. (1) For skilled professional medical personnel and supporting, staff of the medicaid agency or of other public agencies (as defined in §§ 432.2), the rate is 75 percent.

(2) For personnel engaged directly in the operation of mechanized claims processing and information retrieval systems, the rate is 75 percent.

(3) For personnel engaged in the design, development or installation of mechanized claims processing and information retrieval systems, the rate is 50 percent for training and 90 percent for all other costs specified in paragraph (a) of this section.

(4) For personnel of the State licensing agency who are responsible for inspections of skilled nursing or intermediate care facilities, the rate is 100

percent through September 30, 1980:

(i) If a work plan and budget plan relative to this personnel have been approved by the HCFA regional office, and

(ii) Only for those expenditures that are not attributable to the overall cost of meeting the State licensing agency's responsibilities under State law and regulations, but are necessary and proper for carrying out the required inspections.

(5) For personnel administering family planning services and supplies, the rate if 90 percent.

(6) For all other staff of the medicaid agency or other public agencies providing services to the medicaid agency, and for training and other expenses of volunteers, the rate is 50 percent.

(c) Specific limitations. (1) Rates of FFP in excess of 50 percent are applicable only to those portions of the individual's working time that are devoted to the kinds of positions or duties that qualify for those rates.

(2) The special matching rates for persons working on mechanized claims processing and information retrieval systems (paragraph (b)(2) and (3) of this section) are applicable only if the design, development and installation, or the operation, have been approved by the Administrator in accordance with part 433, subpart C, of this subchapter.

42 CFR § 432.55 Reporting training and administrative costs.

(a) Scope. This section identifies activities and costs to be reported as

training or administrative costs on quarterly estimate and expenditure reports to HCFA.

(b) Activities and costs to be reported on training expenditures. (1) For fulltime training (with no assigned agency duties): Salaries, fringe benefits, dependency allowances, travel, tuition, books, and educational supplies.

(2) For part-time training: Travel, per diem, tuition, books and educational supplies.

(3) For State and local medicaid agency staff development personnel (including supporting staff) assigned full-time training functions: Salaries, fringe benefits, travel, and per diem. Costs for staff spending less than full time on training for the medicaid program must be allocated between training and

administration in accordance with 45 CFR 205.150.

(4) For experts engaged to develop or conduct special programs: Salary, fringe benefits, travel and per diem.

(5) For agency training activities directly related to the program: Use of space, postage, teaching supplies, and purchase or development of teaching materials and equipment, for example, books and audiovisual aids.

(6) For field instruction in medicaid: Instructors' salaries and fringe benefits, rental of space, travel, clerical assistance, teaching materials and equipment such as books and audiovisual aids.

42 CFR § 433.10 Rates of FFP for program services.

(a) Basis. Sections 1903(a)(1), 1903(g), and 1905(b) provide for payments to States, on the basis of a Federal medical assistance percentage, for part of their expenditures for services under an approved State plan.

(b) Federal medical assistance percentage (FMAP)-(1) Computation. The FMAP is determined by the formula described in sec. 1905(b) of the Act. Under the formula, if a State's per capita income is equal to the national average per capita income, the Federal share is 55 per cent. If a State's per capita income exceeds the national average, the Federal share is lower, with a statutory minimum of 50 percent. If a State's per capita income is lower than the national average, the Federal share is increased, with a statutory maximum of 83 percent. The formula

used in determining the State and Federal share is as follows:

State share=(State per capita income)^2/
(National per capita income)^{2}x45
per cent

Federal share=100 percent minus the State share (with a minimum of 50 percent and a maximum of 83 percent)

The formula provides for squaring both the State and national average per capita incomes; this procedure magnifies any difference between the State's income and the national average. Consequently, Federal matching to lower income States is increased, and Federal matching to higher income States is decreased, within the statutory 50-83 percent limits. The FMAP for Puerto Rico, the Virgin Islands and Guam is set by statute at 50 percent and is subject to dollar limitations

specified in sec. 1108 of the Act.

(2) Publication. The FMAP for each State is published in the FEDERAL REGISTER in each even-numbered year, effective for a 2-year period beginning October 1 of the next year.

(c) Special provisions. (1) Under sec. 1903(a)(5) of the Act, the Federal share of State expenditures for family planning services is 90 percent.

(2) Under sec. 1905(b), the Federal share of State expenditures for services provided through Indian Health Service facilities is 100 percent.

(3) Under sec. 1903(g), the FMAP is reduced if the State does not have an effective program to control use of institutional services.

42 CFR §433.15 Rates of FFP for admin-

istration.

(a) Basis. Section 1903(a)(2)-(5) and (7) of the Act provide for payments to States, on the basis of specified percentages, for part of their expenditures for administration of an approved State plan.

(b) Activities and rates. (1) Compensation and training of personnel surveying long-term care facilities: 100 percent, through September 30, 1980. (Sec. 1903(a)(4); 42 CFR 432.50(b)(4).)

(2) Administration of family planning services: 90 percent. (Sec. 1903 (a)(5); 42 CFR 432.50(b)(5).)

(3) Design, development, or installation of mechanized claims processing and information retrieval systems: 90 percent. (Sec. 1903(a)(3)(A)(i); 42 CFR part 433, subpart C, and §432.50(b)

(3).)

(4) Operation of mechanized claims processing and information retrieval systems: 75 percent. (Sec. 1903(a)(3)(B); 42 CFR part 433, subpart C and §432.50 (b)(2).)

(5) Compensation and training of skilled professional medical personnel and staff directly supporting those personnel: 75 percent. (Sec. 1903(a)(2); 42 CFR 432.50(b)(1).)

(6) All other activities the Secretary finds necessary for proper and efficient administration of the State plan: 50 percent. (Sec. 1903(a)(7).) (See also §455.300 of this subchapter for FFP at 90 percent for State medicaid fraud controls units under sec. 1903(a)(6).)

42 CFR § 433.112 FFP for design, development, installation of improvement of mechanized claims processing and information retrieval systems.

(a) FFP is available at 90 percent in expenditures for design, development, installation or improvement of a mechanized claims processing and information retrieval system, if the system is approved by the Administrator.

(b) The Administrator will approve the system if the following conditions are met:

(1) The Administrator determines the system is likely to provide more efficient, economical, and effective administration of the State plan.

(2) The system meets the system re-

quirements in part 7-71-00 of the Medical Assistance Manual. et cet.

42 CFR §§ 440.50 Physicians' services.

"Physicians' services," whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided--

(a) Within the scope of practice of medicine or osteopathy as defined by State law; and

(b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.

42 CFR §§ 447.203 Documentation of payment rates.

(a) The agency must maintain docu-

mentation of payment rates and make it available to HEW upon request.

(b) The agency must record, in State manuals or other official files, the following information for increases in payment rates for individual practitioner services:

(1) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used to make the estimate.

(2) An estimate of the composite average percentage increase of the revised payment rates over the preceding rates.

42 CFR § 447.204 Encouragement of provider participation.

The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population.

42 CFR §§ 456.1 Basis and purpose of part.

(a) This part prescribes requirements concerning control of the utilization of medicaid services including--

(1) A statewide program of control of the utilization of all medicaid services; and

(2) Specific requirements for the control of the utilization of medicaid services in institutions.

(b) The requirements in this part are based on the following sections of the Act. Table 1 shows the relationship

between these sections of the Act and the requirements in this part.

45 CFR § 201.2 General.

The State plan is a comprehensive statement submitted by the State agency describing the nature and scope of its program and giving assurance that it will be administered in conformity with the specific requirements stipulated in the pertinent title of the Act, the regulations in Subtitle A and this chapter of this title, and other applicable official issuances of the Department. The State plan contains all information necessary for the Service to determine whether the plan can be approved, as a basis for Federal financial participation in the State program.

45 CFR § 201.3 Approval of State plans and amendments.

The State plan consists of written

documents furnished by the State to cover each of its programs under the Act:

...After approval of the original plan by the Service, all relevant changes, required by new statutes, rules, regulations, interpretations, and court decisions, are required to be submitted currently so that the Service may determine whether the plan continues to meet Federal requirements and policies.

(a) Submittal. State plans and revisions of the plans are submitted first to the State governor or his designee for review in accordance with § 204.1 of this chapter, and then to the regional office. The States are encouraged to obtain consultation of the regional staff when a plan is in process of preparation or revision.

(b) Review. Staff in the regional offices are responsible for review of State plans and amendments. They also initiate discussion with the State agency on clarification of significant aspects of the plan which come to their attention in the course of this review. State plan material on which the regional staff has questions concerning the application of Federal policy is referred with recommendations as required to the central office for technical assistance. Comments and suggestions, including those of consultants in specified areas, may be prepared by the central office for use by the regional staff in negotiations with the State agency.

(c) Action. The Regional Commissioner, or with respect to the medical assistance program under title XIX,

Regional Medicaid Director exercised delegated authority to take affirmative action on State plans and amendments thereto on the basis of policy statements or precedents previously approved by the Administrator. The Administrator retains authority for determining that proposed plan material is not approvable, or that a previously approved plan no longer meets the requirements for approval, except that a final determination of disapproval may not be made without prior consultation and discussion by the Administrator with the Secretary. The Regional Commissioner, or with respect to the medical assistance program under title XIX. Regional Medicaid Director or the Administrator formally notifies the State agency of the actions taken on State plans or revisions. [underlining

supplied]

(d) Basis for approval. Determinations as to whether State plans (including plan amendments and administrative practice under the plans) originally meed or continue to meet, the requirements for approval are based on relevant Federal statutes and regulations. Guidelines are furnished to assist in the interpretation of the regulations.

(e) Prompt approval of State plans. Pursuant to section 1116 of the Act, the determination as to whether a State plan submitted for approval conforms to the requirements for approval under the Act and regulations issued pursuant thereto shall be made promptly and not later than the 90th day following the date on which the plan submittal is received in the regional office, unless

the Regional Commissioner, or with respect to the medical assistance program under title XIX, Regional Medicaid Director has secured from the State agency a written agreement to extend that period.

(f) Prompt approval of plan amendments. Any amendment of an approved State plan may, at the option of the State, be considered as a submission of a new State plan. If the State requests that such amendment be so considered the determination as to its conformity with the requirements for approval shall be made promptly and not later than the 90th day following the date on which such a request is received in the regional office with respect to an amendment that has been received in such office, unless the Regional Commissioner, or with respect to the medical assistance

program under title XIX, Regional Medicaid Director has secured from the State agency a written agreement to extend that period. In absence of request by a State that an amendment of an approved State plan shall be considered as a submission of a new State plan, the procedures under § 201.6(a) and (b) shall be applicable.

(g) Effective date. The effective date of a new plan may not be earlier than the first day of the calendar quarter in which an approvable plan is submitted, and with respect to expenditures for assistance under such plan, may not be earlier than the first day on which the plan is in operation on a statewide basis. The same applies with respect to plan amendments that provide additional assistance or services to persons eligi-

ble under the approved plan or that make new groups eligible for assistance or services provided under the approved plan. For other plan amendments the effective date shall be as specified in other sections of this chapter.
[35 FR 12180,July 29,1970, as amended at 39 FR 34542, Sept. 26, 1974; 42 FR 43977, Sept. 1, 1977]

45 CFR § 201.4 Administrative review of certain administrative decisions.

Pursuant to section 1116 of the Act, any State dissatisfied with a determination of the Administrator pursuant to § 201.3 (e) or (f) with respect to any plan or amendment may, within 60 days after the date of receipt of notification of such determination, file a petition

with the Regional Commissioner, or with respect to the medical assistance program under title XIX, Regional Medicaid Director asking the Administrator for reconsideration of the issue of whether such plan or amendment conforms to the requirements for approval under the Act and pertinent Federal requirements. Within 30 days after receipt of such a petition, the Administrator shall notify the State of the time and place at which the hearing for the purpose of reconsidering such issue will be held. Such hearing shall be held not less than 30 days nor more than 60 days after the date notice of such hearing is furnished to the State, unless the Administrator and the State agree in writing on another time. For hearing procedures, see Part 213 of this chapter. A determina-

tion affirming, modifying, or reversing the Administrator's original decision will be made within 60 days of the conclusion of the hearing. Action pursuant to an initial determination by the Administrator described in such § 201.3 (e) or (f) that a plan or amendment is not approvable shall not be stayed pending the reconsideration, but in the event that the Administrator subsequently determines that his original decision was incorrect he shall certify restitution forthwith in a lump sum of any funds incorrectly withheld or otherwise denied. [35 FR 12180, July 29, 1970, as amended at 42 FR 43977, Sept. 1, 1977]

45 CFR § 201.5 Grants.

To States with approved plans, grants are made each quarter for expen-

ditures under the plan for assistance, services, training and administration. The determination as to the amount of a grant to be made to a State is based upon documents submitted by the State agency containing information required under the Act and such other pertinent facts as may be found necessary.

(a) Form and manner of submittal. (1) Time and place: The estimates for public assistance grants for each quarterly period must be forwarded to the regional office 45 days prior to the period of the estimate. They include a certification of State funds available and a justification statement in support of the estimates. A statement of quarterly expenditures and any necessary supporting schedules must be forwarded to the Department of Health, Education,

and Welfare, Social and Rehabilitation Service, Attention: Finance Division, Washington, D.C. 20201, not later than 30 days after the end of the quarter.

(2) Description of forms: "State Agency Expenditure Projection- Quarterly Projection by Program" represents the State agency's estimate of the total amount and the Federal share of expenditures for assistance, services, training, and administration to be made during the quarter for each of the public assistance programs under the Act. From these estimates the State and Federal shares of the total expenditures are computed. The State's computed share of total estimated expenditures is the amount of State and local funds necessary for the quarter. The Federal share is the basis for the funds to be advanced for the

quarter. The State agency must also certify, on this form or otherwise, the amount of State funds (exclusive of any balance of advances received from the Federal Government) actually on hand and available for expenditure; this certification must be signed by the executive officer of the State agency submitting the estimate or a person officially designated by him, or by a fiscal officer of the State if required by State law or regulation. (A form "Certificate of Availability of State Funds for Assistance and Administration during Quarter" is available for submitting this information, but its use is optional.) If the amount of State funds (or State and local funds if localities participate in the program), shown as available for expenditures is not sufficient to cover the

State's proportionate share of the amount estimated to be expended, the certification must contain a statement showing the source from which the amount of the deficiency is expected to be derived and the time when this amount is expected to be made available.

(3) The State agency must also submit a quarterly statement of expenditures for each of the public assistance programs under the Act. This is an accounting statement of the disposition of the Federal funds granted for past periods and provides the basis for making the adjustments necessary when the State's estimate for any prior quarter was greater or less than the amount the State actually expended in that quarter. The statement of expenditures also shows the share of the Federal

Government in any recoupment, from whatever source, of expenditures claimed in any prior period, and also in expenditures not properly subject to Federal financial participation which are acknowledged by the State agency or have been revealed in the course of an audit.

(b) Review. The State's estimates are analyzed by the regional office staff and are forwarded with recommendations as required to the central office. The central office reviews the State's estimate, other relevant information, and any adjustments to be made for prior periods, and computes the grant.

(c) Grant award. The grant award computation form shows, by program, the amount of the estimate for the ensuing quarter, and the amounts by which the

estimate is reduced or increased because of over— or under-estimate for the prior quarter and for other adjustments. This form is transmitted to the State agency to draw the amount of the grant award, as needed, to meet the Federal share of disbursements. The draw is through a commercial bank and the Federal Reserve system against a continuing letter of credit certified to the Secretary of the Treasury in favor of the State payee. A copy of the grant award notice is sent to the State Central Information Reception Agency in accord with section 201 of the Intergovernmental Cooperation Act of 1968.

(d) Letter of credit payment system. The letter of credit system for payment of advances of Federal funds was established pursuant to Treasury Depart-

ment regulations (Circular No. 1075), published in the FEDERAL REGISTER on July 11, 1967 (32 FR 10201). The HEW "Insturctions to Recipient Organizations for Use of Letter of Credit" was transmitted to all grantees by memorandum from the Assistant Secretary-Comptroller on January 15, 1968.

(e) General administrative requirements. With the following exceptions, the provisions of Part 74 of this title, establishing uniform administrative requirements and cost principles, shall apply to all grants made to States under this part:

45 CFR Part 74

Subpart G— Matching and Cost Sharing.

Subpart I— Financial Reporting Requirements.

[35 FR 12180, July 29, 1970, as amended

at 38 FR 26320, Sept. 19, 1973]

45 CFR § 201.6 Withholding of payments; reduction of Federal financial participation in the costs of social services and training.

(a) When withheld. Further payments to a State are withheld in whole or in part if the Administrator, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of an approved plan, finds:

(1) That the plan no longer complies with the provisions of section 2, 402, 602, 1002, 1402, 1602, or 1902 of the Act; or

(2) That in the administration of the plan there is failure to comply sub-

stantially with any such provision. A question of noncompliance of a State plan may arise from an unapprovable change in the approved State plan, the failure of the State to change its approved plan to conform to a new Federal requirement for approval of State plans, or the failure of the State in practice to comply with a Federal requirement, whether or not its State plan has been amended to conform to such requirement.

(b) When the rate of Federal financial participation is reduced. Under title I, VI, X, XIV, or XVI of the Act, Federal financial participation in the costs of social services and training approved at the rate of 75 per centum is reduced to 50 per centum if the Administrator, after reasonable notice and

opportunity for a hearing to the State agency, finds:

(1) That the plan provision under such title for prescribed services no longer complies with the Federal requirements with respect to such prescribed services; or

(2) That in the administration of the plan there is a failure to comply substantially with such plan provision.

(c) Information discussions. Hearings with respect to matters under paragraph (a) or (b) of this section are generally not called, however, until after reasonable effort has been made by the Service to resolve the questions involved by conference and discussion with State officials. Formal notification of the date and place of hearing does not foreclose further negotiations

with State officials.

(d) Conduct of hearings. For hearing procedures, see Part 213 of this chapter.

(e) Notification of withholding. If the Administrator makes a finding of noncompliance with respect to a matter under paragraph (a) of this section, the State agency is notified that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the plan not affected by such failure), until the Administrator is satisfied that there will no longer be any such failure to comply. Until he is so satisfied, no further payments will be made to the State (or will be limited to categories under or parts of the plan not affected by such failure).

(f) Notification of reduction in the rate of Federal financial participation. If the Administrator makes a finding of noncompliance with respect to a matter under paragraph (b) of this section, the State agency is notified that further payments will be made to the State at the rate of 50 per centum of the costs of services and training, until the Administrator is satisfied that there will no longer be any failure to comply. [35 FR 12180, July 29, 1970, as amended at 39 FR 34542, Sept. 26, 1974]

45 CFR § 201.7 Judicial review.

Any State dissatisfied with a final determination of the Secretary pursuant to § 201.4 or § 201.6(a) may, within 60 days after it has been notified of such determination, file with the U.S. Court

of Appeals for the circuit in which such State is located a petition for review of such determination. After a copy of the petition is transmitted by the clerk of the court to the Secretary, the Secretary thereupon shall file in the court the record of proceedings upon which such determination was based as provided in section 2112 of title 28, United States Code. The court is bound by the Secretary's findings of fact, if supported by substantial evidence. The court has jurisdiction to affirm the Secretary's decision, or set it aside in whole or in part, or, for good cause, to remand the case for additional evidence. If the case is remanded, the Secretary may thereupon make new or modified findings of fact, and may modify his previous determination. The Secretary shall cer-

tify to the court the transcript and record of the further proceedings. The judgment of the court is subject to review by the Supreme Court of the United States upon certiorari or certification as provided in 28 U.S.C. 1254.

45 CFR § 204.2 State plans—format.

State plans for Federally-assisted programs for which the Social and Rehabilitation Service has responsibility must be submitted to the Service in the format and containing the information prescribed by the Service, and within time limits set in implementing instructions issued by the Service. Such time limits will be adequate for proper preparation of plans and submittal in accordance with the requirements for State Governors' review (see § 204.1 of this

chapter).

(Sec. 1102, 49 Stat. 647, 42 U.S.C. 1302; sec. 7(b), 68 Stat. 658, 29 U.S.C. 37(b); sec. 139, 84 Stat. 1323, 42 U.S.C. 2677 (b))

[38 FR 16872, June 27, 1973]

Revision: SRS-AT-76-141 (MSA)

September 3, 1976

STATE PLAN UNDER
TITLE XIX OF THE
SOCIAL SECURITY
ACT
MEDICAL ASSISTANCE
PROGRAM

STATE New York

Citation

45 CFR
Part 201
P.R. 10-9
AT-76-141

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the New York State (single State agency) Department of Social Services submits the following State plan for the medical assis-

tance program, and hereby agrees to administer the program in accordance with the provisions of this State plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

New York Education Law § 6521. Definition of practice of medicine

The practice of the profession of medicine is defined as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition.

New York Education Law § 6522. Practice of medicine and use of title "physician"

Only a person licensed or otherwise authorized under this article shall practice medicine or use the title "physician".

New York Education Law § 6530.[1] Definitions [ARTICLE 131-A[1]--PHYSICIAN'S ASSOCIATES AND SPECIALIST'S ASSIS-

TANTS]

3. Physician. The term "physician" means a practitioner of medicine licensed to practice medicine pursuant to article one hundred thirty-one of this chapter.

New York Public Health Law §§ 3700. Definitions [ARTICLE 37--PHYSICIAN'S ASSISTANTS AND SPECIALIST'S ASSISTANTS]

3. Physician. The term "physician" means a practioner of medicine licensed to practice medicine pursuant to article one hundred thirty-one of the education law.

New York Social Services Law §§ 363-a.

Federal aid; state plan

1. The department shall submit a plan for medical assistance, as required by title XIX of the federal social security act,[1] to the federal department of health, education and welfare for approval pursuant to the provisions of such law and shall act as the single state agency to supervise the administration of the plan in this state. The department shall act for the state in any negotiations relative to the submission and approval of such plan and it may make such arrangements, not inconsistent with law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such law.

MENTAL HYGIENE LAW § 31.02 Operating certificate required

(a) Except as provided in subdivision (b) of this section no provider of services shall engage in any of the following activities without an operating certificate issued by the commissioner pursuant to this article:

1. operation of a residential facility or institution, including a community residence, for the care, custody, or treatment of the mentally disabled; provided, however, that giving domestic care and comfort to a person in the home shall not constitute such an operation.

2. operation of any part of a general hospital for the purpose of providing residential or non-residential

services for the mentally disabled.

3. operation of a facility established or maintained by a public agency, board, or commission, or by a corporation for the rendition of out-patient or non-residential services for the mentally disabled; provided, however, that such operation shall not be deemed to include (i) professional practice, within the scope of a professional license or certificate issued by an agency of the state, by an individual practitioner or by a partnership of such individuals or by a professional service corporation duly incorporated pursuant to the business corporation law or (ii) non-residential services which are licensed, supervised, or operated by another agency of the state and nonresidential services which are chartered or issued a certifi-

cate of incorporation pursuant to the education law or (iii) pastoral counseling by a clergyman or minister, including those defined as clergyman or minister by section two of the religious corporations law. [underlining supplied]

(b) A provider of services operating a community residence on April first, nineteen hundred seventy-six, shall be issued an operating certificate by the commissioner without requiring proof that there is a public need for such residence, providing application for such operating certificate to the department in accordance with this article is submitted prior to September first, nineteen hundred seventy-six. Pending the determination of any such application the continuance of such operation shall be lawful. An applica-

tion pursuant to this section shall be deemed filed with the department upon being mailed to the department by registered or certified mail.

(c) The operation of a facility for which an operating certificate is required shall be in accordance with the terms of the operating certificate and the regulations of the commissioner.

(d) Any provider of services who knowingly fails to comply with the provisions of this section or of section 31.03[1] of this chapter shall be guilty of a misdemeanor.

Formerly § 13.01, L.1972 c.251; amended L.1972, c.254, § 2; L.1975, c.804, § 2; renumbered 13.02, L.1976, c.328, § 1; renumbered 31.02, L. 1977, c. 978, § 34.

[1]Section 31.03 was 13.02 prior to the renumbering by L.1977, c.978.

State Medical Handbook

46.4 Review of Care

A. Out-patient care

1. If a patient requires more than 15 visits or, in any case, by the end of 90 days, a treatment plan to include diagnosis, progress achieved in care already rendered, course of future management and prognosis will be provided by the practitioner or facility for review by the local medical director. The treatment plan is to be submitted before, or at the 15th visit or the 90th day, whichever comes first. Such reports of treatment

plans will be referred to the local mental health consultant for advice, opinion and recommendation. However, care need not be interrupted pending such review.

2. At the time of such review, decision should be made for date of next review.

3. When out-patient care has continued over an extended period of time and where the prognosis is unfavorable or indefinite or where no progress or only insignificant progress has been achieved, review

by the local medical director with a local mental health consultant is particularly indicated, (see 46.3 above). In such review, consideration should be given to the advisability of a modification in the treatment plan. Such modification could include change in goals and general approach (provision of maintenance or supportive service rather than more intensive therapy); change in method of provision of care; in time interval for provision of services; etc.

Legislative History

P.L. 89-97 U.S. Code Cong. and Adm. News p.2292; 2295.

Mr. MILLS: "...It has never been our intention to limit the authority of physicians who have been licensed under State law." p.2292.

Mr. HALL: "I notice that doctors of medicine are covered under the basic social security laws on an involuntary basis whether they like it or not. I must say, I regret that but I am glad that physicians have been defined in the Conference report." p.2295.

P.L. 89-751 Allied Health Professions Personnel Training Act.

P.L. 91-519 Health Training Improvement Act of 1970. U.S.

Legislative History

Code Cong. & Adm. News
4755; 4756; 4763; 4765

SUMMARY

The bill would add new authorities for aid to allied health students through loans, scholarships, and work study programs, and a liberalized veterans educational assistance allowance.

p.4755

Purposes

In addition to the presently authorized purposes, the bill would authorize projects—

—to study and develop mechanisms for determining the equivalency and proficiency of previously acquired knowledge and skills related to the allied health professions

Legislative History

—to develop, demonstrate, and evaluate new means of recruiting, retraining, or retention of allied health personnel.

It would also clarify the present authority for projects—

—to develop, experiment with, and demonstrate new teaching methods and curriculums related to the allied health professions.

Equivalency and proficiency mechanisms have far-reaching implications for the health occupations. They can be used to accelerate the formal academic programs for allied health personnel by advanced placement. They can serve as a sound basis for occupational mobility. They can make it possible for many allied health workers to undertake additional

advanced training with appropriate recognition of the principles and techniques they have mastered. This is particularly true in the case of the returning veteran who has had training and experience in a health field while serving in the armed forces.

New sources of allied health manpower must be tapped and we must make optimum use of persons with previous experiences in the health fields, including returning veterans with experience in the health fields who could use their training and experience in the civilian health sector, and former practitioners who have left the field and could return if refresher courses were available. [underlining added] pp.462-463

Legislative History

The bill would afford a special incentive for veterans undertaking allied health training. It would provide that educational allowances for veterans pursuing a course of study in one of the allied health professions are to be paid without charge to any period of entitlement the veteran may have earned.
p.4765

P.L. 92-603 U.S. Code Cong. and Adm. News p. 5307.

Section 241 of the bill amends title XI of the Social Security Act by adding at the end a new section 1123.

Subsection (a) of the new section 1123 requires the Secretary (in consultation with appropriate professional organizations and State health and li-

censure agencies) to develop and conduct a program to determine the proficiency of those persons who do not meet the educational, professional membership, or other criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians and technologists, X-ray technicians, psychiatric technicians, or other health care technicians. This program will include (but not be limited to) the use of procedures for the formal testing of the proficiency of such personnel. No person who otherwise meets the proficiency requirements may be denied a satisfactory proficiency rating solely for failure to meet formal educational or professional membership requirements.

Legislative History

Subsection (b) of the new section 1123 provides that no person or provider using the health care services of an individual determined qualified under section 1123(a) may be denied payment under title XVIII or under State plans approved under title XIX on the grounds that such individual is not qualified to perform these services

P.L. 94-484 42 USC § 292: Congressional Findings and Declaration of Policy.

Section 2 of Pub. L. 94-484 provided that:

"(b) The Congress further finds and declares that—

"(1) health professions personnel are a national health resource and the Fed-

Legislative History

eral Government shares the responsibility of assuring that such qualified personnel are available to meet the health care needs of the American people."

P.L. 94-552 U.S. Code Cong. and Adm. News p. 5649; p. 5652.

..."shared health care facilities"—the so-called Medicaid mills. p.5649

Recent investigations of so-called "Medicaid mills" unregulated and poorly equipped storefront units located in ghetto areas—have documented the pervasive nature of fraudulent and abusive practices and the woefully inadequate and substandard care rendered in such locations. The most common violations in the "mills" include:

Legislative History

(1) "ping-ponging"—referral of patients from one practitioner to another within the facility even though there is no medical reason for doing so;

(2) "ganging"—billing for multiple services to the same family on the same day;

(3)"upgrading"—billing for a service more extensive than that actually provided;

(4) "steering"—direction of a patient to a particular pharmacy, a violation of his freedom of choice; and

(5) billing for services not rendered—either adding services not performed onto an invoice carrying legitimate billings or submitting a

totally fraudulent claim. Other documented violations included billing for work performed by others or by unlicensed practitioners; making multiple copies of Medicaid cards; soliciting, offering, or receiving kick-backs; double billing; and billing both Medicare and Medicaid for the same service.

Fraudulent and abusive practices are not limited to Medicaid mills; clinical laboratories are another location where pervasive violations have been shown to occur. Recent investigations of such facilities found that kick-backs are so prevalent that in some areas laboratories refusing to take them are practically unable to secure business of physicians or clinics treating Medicaid

patients. Kick-backs take a number of forms including cash, gifts, long-term credit arrangements, supplies, equipment, and furnishing business machines. The most common practice, however, involves the supposed rental of a small

[page 6]

office space in a medical clinic. The billing practices employed by these laboratories are also often highy questionable. Techniques which constitute abuse or actual fraudulent practices include charging for services not ordered by the physician; charging for inappropriate tests not ordered by the patient's physician; charging Medicaid more than private patients; billing Medicaid patients for automated parts of profile tests; and use of forms supplied by the labor-

Legislative History

atory which make it impossible for physicians to order certain lab tests without ordering related tests. Profiteering, at the expense of patients, has also been shown to exist in the country's nursing homes where gang visits, kick-backs, collecting duplicate payments from Medicare and Medicaid, and billing for deceased or discharged patients are not unusual practics. p. 5652

P.L. 95-142 U.S.Code Cong. and Adm. News p.3050.

Program abuse is less clearly defined and includes activity wherein providers, practitioners, and suppliers of services operate in a manner inconsistent with accepted, sound medical or business

Legislative History

practices resulting in excessive and unreasonable financial cost to either medicare or medicaid. Included in the area of abuse are the provision of unnecessary health services and the provision of necessary care in unnecessarily costly settings. p. 3050

Legislative History

1908 Op. Atty.Gen. 552 McKinneys 1972,p.236.

An unregistered employee working on a salary for a registered physician cannot write prescriptions for and treat patients and take fees therefor during his employer's absence.

1933 Op. Atty.Gen. 48 St. Dpt. Reports p.133

Education Law, article 42.

Definition of "practice of medicine" is set out in Education Law article 42 and a physician's practice may be as extensive as the definition.

The Department of Education has referred to this office your request for a ruling upon whether a graduate of

Legislative History

both a medical and osteopathic school who receives a license to practice medicine and surgery in the State of New York is lawfully entitled to practice osteopathy without obtaining a license to practice osteopathy.

The Education Law provides:

"Section 1250. Definitions.

* * * * * * *

"7. The practice of medicine is defined as follows:

A person practices medicine within the meaning of this article, except as hereinafter stated, who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by means or method, to diagnose, treat,

operate or prescribe for any human disease, pain, injury, deformity or physical condition."

There is no restriction in the statute limiting the practice of the holder of a license to practice medicine and surgery. His practice may, therefore, be as extensive as the definition.

You are aware, no doubt, that the Attorney-General acts as legal advisor only to the officials and departments of the State. The foregoing statement is, accordingly, furnished informally for your information.

Dated December 14, 1933.

To Howard B. Herdeg, D.O.,
677 Parkside Ave.,
Buffalo.

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Laws of New York 1947

Education Law Art. 131 §6501.// 4;// 5

§6501. Definitions.

4. The practice of medicine is defined as follows: A person practices medicine within the meaning of this article, except as hereinafter stated, who holds himself out as being able to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition, and who shall either offer or undertake, by any means or method, to diagnose, treat, operate or prescribe for any human disease, pain, injury, deformity or physical condition.

5. "Physician" means a practitioner of medicine.

PHYSICIAN'S ASSOCIATES AND SPECIALIST'S* ASSISTANTS--AUTHORIZATION

On approving L.1971, c.1135, the Governor stated:

July 6, 1971

The bill establishes two new categories of health professionals--Physician's Associates and Specialist's Assistants--to assist physicians in carrying out a full range of medical services. The bill also establishes a Veterans Health Manpower Center in the Department of Health.

The severe shortage of health manpower now being experienced throughout the United States and in this State is a matter of grave concern. Nearly 200 areas in our State with a population of

---

*McKinney's Session Laws p.2642

1,200 or more lack adequate coverage by practicing physicians. Rural, urban and suburban areas are all affected. It is an unfortunate fact that physicians are now at times forced to "short cut" a desirable practice or procedure in order to conserve time.

Sheer physical limitations on the number of patients one physician can care for make it essential that there be available adequately trained assistants upon whom physicians can rely to bring better medical care to a greater number of persons. Adequately trained associates working under the supervision of licensed physicians can significantly increase not only the quantity but the quality of medical care available.

The bill, which adds Physician's Associates and Specialist's Assistants

to the health care team, represents an important step in the continuing campaign to alleviate the health manpower shortage.

This registration program offers the real prospect of substantially reducing the health manpower shortage.

The bill is approved.

Nelson A. Rockefeller

PHYSICIAN'S ASSOCIATES AND SPECIALIST'S* ASSISTANTS--DUTIES

On approving L.1971, c.1136, the Governor stated:

July 6, 1971

The bill amends Senate Bill 5703, which I have earlier approved, providing for the creation of the new health categories of Physician's Associate and Specialist's Assistant.

Some of the comments I have received on this chapter amendment indicate a concern that it would severely curtail the type of duties which a physician's associate or specialist's assistant can perform.

The language of the bill refers only to "those 'specific' functions and duties

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*McKinney's Session Laws p.2643

'specifically' delegated by law to those persons licensed as allied health professionals under the Public Health Law or the Education Law." Those provisions are intended to insure that the specialist's assistant will not displace or be in direct competition with certain allied health professions already licensed, such as optometrists and podiatrists, not to prohibit any activities in the fields of optics or foot care. In a related health profession, it is my hope that the nursing profession will continue to have an expanding role in health care, but the Education Law does not "specifically" delegate "specific functions" in the definition of nursing. Obviously, if a physician's associate or a specialist's assistant were precluded from doing anything which nurses or other health pro-

fessionals are authorized to do, there would be little else left for them. While physician's associates and specialist's assistants are not intended to in any way replace existing health professionals, they necessarily will perform many of the same duties.

I am sure that the Health Department can clarify any confusion which might exist by appropriate administrative regulation.

The bill is approved.

Nelson A. Rockefeller

Opposition

Office - Supreme Court, U.S.
FILED
DEC 28 1981
ALEXANDER L. STEVAS,
CLERK

NO. 81-860

IN THE
Supreme Court of the United States

OCTOBER TERM, 1981

ALVIN R. YAPALATER, M.D.,

Petitioner,

-vs-

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistasnce of the New York State Department of Health,

Respondents.

BRIEF FOR RESPONDENTS BATES AND LEFKOWITS IN OPPOSITION TO THE PETITION FOR CERTIORARI

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1981

No. 81-860

ALVIN R. YAPALATER, M.D.,

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CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

Respondents.

BRIEF FOR RESPONDENTS BATES AND LEFKOWITS IN OPPOSITION TO THE PETITION FOR CERTIORARI

Preliminary Statement

This brief is submitted on behalf of respondents Charles W. Bates and Henry J. Lefkowits (hereinafter the "County respondents") in opposition to the petition for certiorari which seeks review of an order of the United States Court of Appeals for the Second Circuit, which unanimously affirmed an order of the United States District Court for the Southern District of New York (Haight, D.J.) dismissing the complaint of petitioner Alvin R. Yapalater, M.D. (hereinafter "petitioner").

Jurisdiction

Petitioner purports to invoke the jurisdiction of this Court under 28 U.S.C. 2101(c) (petitioner's brief at pages 5-6).

Counter-Statement Of Question Presented*

Whether the insufficiency of the record below precludes this Court from exercising its discretion to grant certiorari?

Statutory Provisions Involved

The statutory and regulatory provisions involved are cited and set out in the appendix to petitioner's brief at pages A 202 through A 271 and in the New York State respondent's brief in the supplemental appendix.

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*To the extent that the Attorney General of the State of New York has briefed the issues responsive to the questions presented by petitioner on behalf of the New York State respondents, the County respondents adopt the State's brief to avoid burdening the Court.

Statement Of The Case

In or about March, 1979, petitioner began to submit claims to the County respondents in which he sought payment under the New York State Medicaid Plan for psychotherapy he allegedly personally rendered to Medicaid recipients. The County declined to process these claims as it appeared that petitioner had not performed the psychotherapy for which he billed. However, he refused, despite repeated demand, to furnish information sufficient to enable the County respondents to determine whether the remainder of the claims submitted were factually correct or whether they otherwise qualified for

payment (T:284; affidavit of Henry J. Lefkowits, M.D., sworn to June 25, 1980)*. The Medicaid regulations of the New York State Department of Social Services (10 NYCRR 85.28) required that psychiatric care be provided by a qualified psychiatrist, and prohibited the County respondents from making payment for such services performed by others.

The timing of the commencement of petitioner's independent billing was not fortiutous. Rather, it coincided

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*Numerical references preceded by the letter "T" refer to the pages of the transcript of the trial of the within action.

with New York State court decisions declaring that Psychiatric Service Center, Inc. (hereinafter "PSCI"), was ineligible to receive Medicaid payments.*

PSCI, a methadone clinic employing as therapists persons of questionable qualifications who did not possess the appropriate licenses to practice medicine (T:436-441), was established by petitioner in 1974 to take advantage of Medicaid reimbursement laws (T:46-57). Petitioner was PSCI's

*Psychiatric Services Center, Inc. v. Bates, et al., 73 A.D.2d 935 (2nd Dept. 1980). By decision and order dated December 22, 1980, the New York Court of Appeals unanimously affirmed the Appellate Division, ruling that PSCI was "ineligible to receive Medicaid payment or reimbursement for the psychiatric clinic care it rendered." Psychiatric Services Center, Inc., v. Bates, et al., 52 N.Y. 2d 788 (1981).

director (T:41). Both shared the same office, employed the same personnel, and treated the same patients (T:27, 32-35, 53-56). The mode of treatment employed by PSCI and petitioner was identical (T:32-35).

The County respondents suspected that petitioner's submission of bills in his own name was an attempt to circumvent the New York courts' decision by laundering claims to the Medicaid program for work performed by PSCI's non-medical employees. Subsequently, these suspicions were confirmed. Petitioner admitted that he was "on behalf of PSCI submitting bills to the [County] for patients who were being treated by PSCI", "for whom PSCI submitted bills in the

past", and for whom the County was refusing to pay PSCI (T:261-62, 264-65, 268-70).

Having exhaused his state appellate remedies without success under the name of PSCI, petitioner instituted the within action in his own name in the United States District Court for the Southern District of New York. The trial court, without discussion of the factual deficiencies in the record, dismissed the complaint and ruled that as a matter of law, the services rendered by PSCI's non-medical staff members were not entitled to reimbursement under the federal regulations governing Medicaid. The United States Court of Appeals for the Second Circuit unanimously affirmed the District Court on the opinion below.

The Southern District's opinion is reported at 494 F. Supp. 1349 (S.D.N.Y. 1980), and is reproduced in the appendix to petitioner's brief at pages A 10 through A 94. The decision of the Second Circuit is reported at 644 F. 2d 131 (2nd Cir. 1981), and is reproduced in the petitioner's brief at pages A 1 through A 6 of the appendix.

Argument

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED

The decisions below were correct without regard to the questions sought to be raised in the petition.

Notwithstanding the interpretation of the applicable federal statutes and regulations, petitioner failed to adduce sufficient evidence at trial to support the relief sought. The record is bereft of competent or credible evidence tending to identify and separate petitioner's claims from those of PSCI. The record is also sorely lacking in facts tending to establish that petitioner complied with Medicaid regulations, including the requirements of supervision of ancillary personnel.

The only fact clearly established is that petitioner, in a bare attempt to circumvent the rulings of the New York courts, submitted bills to the County for patients who were being treated not by himself, but by PSCI.

This Court should decline to exercise its discretion to grant certiorari due to the patent insufficiency of the record below. Assuming arguendo, that the lower courts' rulings were erroneous, it would be impossible for the Court to adjudicate this case without a proper factual predicate upon which to construe the relevant statutory and regulatory provisions at issue.

Since it is manifestly unclear on the record how many of PSCI's bills

petitioner attempted to launder, it is evident that should this Court determine that both courts below incorrectly interpreted the federal regulations at issue, petitioner is at best entitled to a remand for further fact finding. However, as petitioner has continuously been unwilling or unable to provide information enabling PSCI's bills to be separated from his own, serious question remains whether a remand would further advance his cause. Surely, after three days of trial, if facts establishing petitioner's claims were in existence, they could have been introduced. Their absence enables the strong inference to be drawn that petitioner is unable to determine either the number or the identity of the patients to whom he actually rendered care.

Conclusion

The petition for a writ of certiorari should be denied.

Dated: White Plains, New York
December 21, 1981

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ERIC D. KOSTER
Senior Assistant County Attorney
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Opposition

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No. 81-860

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CLERK

IN THE

Supreme Court of the United States

October Term, 1981

ALVIN R. YAPALATER, M.D.,

Petitioner, Pro se,

v.

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR STATE RESPONDENTS IN OPPOSITION

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Questions Presented*

1. Is there a conflict between Title XIX of the Social Security Act and New York State law which limits reimbursement of private psychiatrists' Medicaid claims for services rendered by persons other than themselves to a limited number of adequately supervised State certified social workers?

2. Is petitioner's right to equal protection of the laws denied by the State regulations applicable to Medicaid reimbursement which differentiate between services provided in a hospital or psychiatric clinic and those provided by private psychiatrists?

Parties

The parties to this appeal are set forth in the caption.

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* Petitioner's Questions Presented for Review are improper in that they raise issues which are not within this Court's scope of review and which were not raised in the Courts below.

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Petitioner has failed to state any basis upon which this Court should exercise its discretion to review his claims. No allegation of a conflict between the Circuits or a conflict between federal and state court decisions on this issue is presented. Nor has the petitioner raised an important question of federal law which has not been decided by this Court or which is in conflict with applicable decisions of this Court	9

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No. 82-860

IN THE

Supreme Court of the United States

October Term, 1981

ALVIN R. YAPALATER, M.D.,

Petitioner, Pro se,

v.

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF FOR STATE RESPONDENTS IN OPPOSITION

Opinions Below

The order of the Court of Appeals for the Second Circuit denying rehearing is unpublished and is reproduced in the Appendix to the Petition at pp. "A" 7-9.* The opinion of the Court of Appeals is reported at 644 F.2d 131 and reproduced in the Appendix to the Petition at pp. A 1-6. The opinion and order of the District Court are reported at 494 F. Supp. 1349 and are reproduced in the Appendix to the Petition at A 10-94.

Jurisdiction

Petitioner erroneously relies upon 28 U.S.C. § 2101(c) to invoke the jurisdiction of this Court.**

The judgment of the Court of Appeals was filed on March 25, 1981. The mandate of the Court of Appeals was issued on April 15, 1981. By motion dated April 22, 1981, petitioner moved for a stay of the mandate in the Court of Appeals. As petitioner's motion was untimely (App. Rule 41), he subsequently moved by notice of motion dated May 18, 1981, requesting that the mandate be recalled. By order dated June 30, 1981, the Court of Appeals granted petitioner's motion for recall of the mandate and stay of the mandate.

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* "A" references are to the Appendix to the Petition.

** The Courts below held that petitioner, as a provider of services, arguably reimbursable under Medicaid, stated a cause of action under the Social Security Act for which 42 U.S.C. § 1983 provided a remedy. *Maine* v. *Thiboutot*, 100 S.Ct. 2502 (1980). Recent decisions by this Court, however, raise the question of whether petitioner has an enforceable right under the Social Security Act. *Pennhurst Hospital* v. *Halderman*, 101 S.Ct. 1531 (1981); *Middlesex County Sewerage Authority* v. *National Sea Clammers Association*, 101 S.Ct. 2615 (1981).

By motion dated July 10, 1981, petitioner moved the Court of Appeals to "Reenter Judgment in Order to Effect a Period of Time in which [to] Petition for Certiorari", because the period of time in which to petition this Court had expired (28 U.S.C. § 2101[c]). The Court of Appeals treated petitioner's motion as a petition for rehearing and by order dated August 10, 1981, denied the petition and ordered the mandate to go down in due course (A 7-9). This office was served by mail with the petition for a writ of certiorari on November 6, 1981.

Constitutional and Statutory Provisions

United States Constitution

U.S. Constitution, Amendment XIV, § 1, provides in pertinent part:

> ". . . No State shall . . . deny to any person within its jurisdiction the equal protection of the laws."

The Constitution of the United States of America (House Document No. 93-414, 93rd Congress, 2d Session, p. 21 [1975]).

Petitioner has placed the following federal statutes and regulations in issue: Title XIX of the Social Security Act (42 U.S.C. § 1396 *et seq.*) (A 205-214) and 42 C.F.R. § 440.50 (A 230).

Petitioner has placed the following State statutes and regulations in issue: New York Education Law Article 131, § 6520 *et seq.* (A 261); Article 131-b, § 6540 *et seq.* (A 261-262); Public Health Law § 3700 (A 263); Social

Services Law § 363 *et seq.* (A 264); Health Regulation 10 NYCRR 85.32 and Social Services Regulation 18 NYCRR 505.15. The regulations are reproduced in the Supplemental Appendix hereto.

Statement of the Case

Petitioner, a private practicing psychiatrist in New York State, instituted this action on the premise that he was entitled to be reimbursed for services rendered, allegedly under his personal supervision, by various ancillary personnel.* The County respondents, in accordance with State guidelines, refused to process petitioner's reimbursement claims with respect to the ancillary personnel. Petitioner alleged a conflict between the State Plan and its exclusion of reimbursement to private psychiatrists for ancillary personnel except social workers and the Social Security Act (42 U.S.C. § 1396 *et seq.*) and denial of equal protection of the laws.**

* Prior to January 30, 1980, the New York State Medical Assistance Program ("State Plan") (N.Y. Social Services Law, Title 11, § 363 *et seq.*) and the regulations promulgated thereunder had no provision for such reimbursement. The regulations were subsequently amended to provide reimbursement under specified conditions for certain of the ancillary services, i.e., those of social workers (*supra*, p. 6).

** The petition includes a "due process claim" as part of the statement of the case (Petition p. 13). However, the District Court deemed the claim abandoned in that the allegations in the complaint were purely conclusory, plaintiff adduced no evidence on the claim at trial and no reference was made to such a claim in plaintiff's counsel's closing argument (see District Court decision, fn. 15, A 94). Nor did petitioner raise a due process claim on appeal to the Second Circuit.

A. Federal Statutory Framework

Title XIX of the Federal Social Security Act (42 U.S.C. § 1396 *et seq.*) establishes the framework for state-operated Medical Assistance (Medicaid) programs. In order to obtain Federal Financial Participation ("FFP") in its Medicaid program, a State plan must provide reimbursement for "physician's services furnished by a physician" (42 U.S.C. § 1396a[13][c][i]; 42 U.S.C. § 1396d[a][5]). The term "physician" is defined as ". . . a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or actions . . ." (42 U.S.C. § 1395x[r][1]).

The Department of Health and Human Services ("HHS"), formerly the Department of Health, Education and Welfare ("HEW"), has promulgated regulations for the implementation of Title XIX. Physician's services are defined by 42 C.F.R. § 440.50 as follows:

> "Physicians' serviced [*sic*], whether furnished in the office, the recipient's home, a hospital, a skilled nursing facility, or elsewhere, means services provided—
>
> (a) Within the scope of practice of medicine or osteopathy as defined by State law, and
>
> (b) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy."

B. State Statutory Framework

Social Services Law Section 364 provides that both the Department of Social Services and the Department of Health shall be responsible for promulgating regulations for

establishing and maintaining the standards of care rendered pursuant to the State plan to assure that the quality of medical care and services is in the best interest of the recipients. The regulations so promulgated are found in 18 NYCRR § 505.1 *et seq.* (Social Services) and 10 NYCRR § 85.1 *et seq.* (Health) (Supplemental Appendix pp. 12-15).

State law defines the practice of medicine in Education Law, Article 131, § 6520 *et seq.* "... as diagnosing, treating, operating or prescribing for any human disease, pain, injury, deformity or physical condition." Section 6522 provides that "[o]nly a person licensed or otherwise authorized under this article shall practice medicine or use the title 'physician' ".*

Pursuant to the State Plan, psychiatric care in New York is available from any of three provider groups: hospitals certified under Article 28 of the Public Health Law (Public Health Law § 2800 *et seq.*); clinics under contract with local community Mental Health Boards or operated by the State Department of Mental Hygiene (14 NYCRR Part 100); and psychiatrists acting as private practitioners (18 NYCRR 505.15; 10 NYCRR 85.28).

Medicaid reimbursement for private psychiatrist or outpatient psychiatric care is governed by Department of Health Regulations, Sections 85.28-85.31 and by Department

* In addition, Education Law Article 131-b (§ 6540 *et seq.*) provides for the registration of "physician's assistants" and "specialist's assistants". The services which these individuals may provide and the supervision under which they must perform are precisely defined. The New York Public Health Law echoes the limitations set forth in the Education Law (Public Health Law § 3700 *et seq.*). There is no physician's or specialist's assistant certification for psychiatry.

of Social Services regulations 18 NYCRR § 505.15. A private practicing physician will be reimbursed for services personally provided and for social work services provided by a social worker, practicing under the direct supervision of a psychiatrist in private practice, as part of the course of treatment provided by the supervising psychiatrist.

C. Administrative Interpretations

Between 1978 and 1980, the Regional Medical Director of HEW (now HHS) Arthur J. O'Leary and the Department of Social Services ("DSS") corresponded concerning the interpretation and implementation of 42 C.F.R. § 440.50. In essence, HEW interpreted § 440.50 as mandating reimbursement to a private practicing physician for services rendered by all ancillary personnel under the supervision of a physician.* Petitioner bases his claims upon this interpretation of the federal regulation.

The State took the position that the nature of services which were to be included within the definition of the scope of the practice of medicine is a question of State law and, therefore, State interpretation. Since the services of various ancillary personnel are generally not within the scope of the practice of medicine in New York, a physician would not be reimbursed for services provided by others, even if under the direction of a supervising physician, unless specifically provided for by regulation. The State's position appears in a letter from David P. Glasel, DSS Deputy Commissioner and General Counsel to defendant Blum, and is reproduced in the Supplemental Appendix at pp. 5a-7a.

* The position taken by HHS is stated in a 1979 letter from Mr. O'Leary to respondent Blum and is reproduced in the Appendix to the Petition at A 131-137.

During the hearing below the District Court solicited HHS's interpretation of 42 C.F.R. § 440.50. HHS responded by letter to which copies of previous correspondence, already part of the record, were attached (A 157-162). The District Court noted that by attaching its previous correspondence, HHS apparently intended to ratify and reaffirm its prior position. However, Judge Haight also pointed out that the letter could be read to support the defendants' construction of § 440.50 and was a "possible retreat" from its former position (A 66).

D. The District Court Opinion and Order

The District Court rejected the interpretation of 42 C.F.R. § 440.50 asserted by the petitioner, and arguably HHS, in that it would result in mandated Medicaid reimbursement for the services of literally anybody, regardless of whether they were included within State statutes or regulations (A 59-65). The District Court specifically held that such an interpretation contradicts the authority given to the State by both Title XIX of the Social Security Act and § 440.50 itself to utilize the State law definitions of the scope of medical practice (A 60).

The Court also found plaintiff's claim of denial of equal protection to be without merit and that the central question of the case did not involve a fundamental right explicitly or implicitly protected by the Constitution (A 70). The Court concluded that petitioner's constitutional rights have not been infringed and that the State defendants' regulations and practices were rationally related to a legitimate governmental interest (A 86).

The Court of Appeals affirmed on the opinion below (A 1-6).

Reasons for Denying the Petition for Certiorari

Petitioner has failed to state any basis upon which this Court should exercise its discretion to review his claims. No allegation of a conflict between the Circuits or a conflict between federal and state court decisions on this issue is presented. Nor has the petitioner raised an important question of federal law which has not been decided by this Court or which is in conflict with applicable decisions of this Court.

1. Petitioner's equal protection claim is foreclosed from review by prior decisions of this Court.

It is well settled that the analysis of an equal protection claim will require strict judicial scrutiny only if the statutory scheme under review operates to the disadvantage of a suspect class or impinges upon a fundamental right explicitly or implicitly protected by the Constitution. *Maher* v. *Roe,* 432 U.S. 464 (1977); *San Antonio School Dist.* v. *Rodriguez,* 411 U.S. 1 (1973). The petitioner, a private practicing psychiatrist, clearly does not fall within a suspect classification as defined by this Court. Nor is reimbursement to providers of Medicaid services a fundamental right protected by the Constitution. Thus, petitioner's claim must be rejected upon a showing by the State that its Medicaid reimbursement plan is rationally related to a legitimate governmental purpose and has some reasonable basis. *United States Dept. of Agriculture* v. *Moreno,* 413 U.S. 528 (1973); *Massachusetts Board of Retirement* v. *Murgia,* 427 U.S. 307 (1976); *Dandridge* v. *Williams,* 397 U.S. 471 (1970).

Petitioner seeks review of the Second Circuit's affirmance of the District Court's opinion and order on the identical arguments presented below. The District Court

extensively reviewed petitioner's claims in light of the State's policies and practices regarding reimbursement of Medicaid claims for services rendered by private practicing psychiatrists. The Court found that the State had a legitimate governmental purpose of ensuring that a high standard of medical care be delivered to Medicaid recipients and in preventing the creation of psychiatric services "mills" (A 83-84). The Court also noted that the State is entitled to expand reimbursement for services rendered under the supervision of a physician in a gradual manner without depriving the petitioner of his constitutional right to equal protection of the laws (A 84-85). *Railway Express Agency, Inc.* v. *New York*, 336 U.S. 106 (1949).

2. The District Court's statutory construction of the New York State Medicaid Program as being in compliance with Title XIX of the Social Security Act and the regulations promulgated thereunder is in conformance with prior decisions of this Court.

Petitioner also urges this Court to grant his petition upon the ground that the District Court did not accord the proper degree of deference or ascribe a sufficient degree of weight to the interpretation of 42 C.F.R. § 440.50 proffered by HHS. It is well settled that in order to be accorded weight by a Court, an administrative interpretation must be consistent with the underlying statute, its own regulation and prior pronouncements of the agency. *Udall* v. *Tallman*, 380 U.S. 1, 4 (1965); *Bowles* v. *Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945); *Nico* v. *Commissioner of Internal Revenue*, 565 F.2d 1234, 1237 (2d Cir. 1977).

That the interpretation of § 440.50 by HHS as set forth in the O'Leary letters (A 121-156) possibly supports the

petitioner's interpretation does not change the plain meaning of § 440.50. The "O'Leary letters" do not constitute regulations or even guidelines of HHS. Furthermore, the response by HHS to the District Court may be read to support the respondent's position. In any event, the agency interpretation of § 440.50 was rejected by the District Court for the simple reason that carried to its logical conclusion, it would mandate reimbursement for services rendered by any untrained, unskilled or nonlicensed individual a physician chose to supervise.

The District Court acted in accordance with the guidelines established by this Court in determining the degree of judicial deference to be afforded an agency decision when presented with a question of statutory reading and analysis. See, *e.g.*, *United States* v. *Larionoff*, 431 U.S. 864 (1977); *Schweiker* v. *Gray Panthers*, —— U.S. ——, 101 S.Ct. 2633 (1981).

Conclusion

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Dated: New York, New York
December 21, 1981

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for State Respondents

SHIRLEY ADELSON SIEGEL
Solicitor General

ELLEN J. BRONZO
Assistant Attorney General
Of Counsel

SUPPLEMENTAL APPENDIX

Supplemental Appendix

Title 10 of the Department of Health Administrative Rules and Regulations provides in pertinent part:

Outpatient Psychiatric Care

85.28 Applicability and general requirements. (a) Sections 85.28 through 85.30 of this Part shall only apply to outpatient psychiatric care provided by a private practicing psychiatrist.

(b) A private practicing psychiatrist is a physician who renders treatment to a patient on a fee-for-service basis and who is compensated for those services directly through the medical assistance for the needy program, except that payment for services may be made directly to a professional corporation or partnership in which the private practicing psychiatrist is a member or with which the private practicing psychiatrist is associated, or in the case of a shared health facility as provided in subsection 8 of section 4708 of the Public Health Law.

(c) To be a covered benefit under medical assistance for the needy as provided in section 365-a.2 of the Social Services Law, outpatient psychiatric care rendered by a private practicing psychiatrist must be provided by a qualified psychiatrist in accordance with the requirements of sections 85.28 through 85.30 of this Part.

(d) A qualified psychiatrist shall meet the requirements contained in the Social Services regulations (18 NYCRR 505.2).

85.32 Social work. (a) Social work services may be provided by a social worker, practicing under the direct supervision of a qualified psychiatrist in private prac-

tice as part of a course of treatment provided by the supervising psychiatrist.

(b) For purposes of this section, the term *social worker* shall mean a person authorized pursuant to the Education Law to use the title "certified social worker."

(c)(1) A social worker may provide services only under the continuing direct supervision of a qualified psychiatrist. Such supervision must include regular communication and consulation between the social worker and the supervising psychiatrist, but shall not be construed as requiring the physical presence of the supervising psychiatrist at the time the services are being performed by the social worker. The number of social workers supervised by the supervising psychiatrist shall not exceed four.

(2) Duties and responsibilities performed by the social worker must be assigned to him by the supervising psychiatrist, within the scope of practice of the supervising psychiatrist, and appropriate to the education, training and experience of the social worker.

(3) The provision of services by a social worker must be preceded by the completion of a diagnostic evaluation of the patient by the supervising psychiatrist.

(4) The supervising psychiatrist shall be responsible for developing an overall treatment plan pursuant to section 85.29 of this Part, which integrates the social worker's study of the patient, and describes the services to be provided by the social worker.

(5) When enrolling in the medical assistance program, a supervising psychiatrist must provide the Department of Social Services with the names of any social workers for whose services he may bill.

(d) The services provided by the social worker may include the following:

(1) the taking of a social history, if taken during an office visit, which shall include all relevant information useful to the patient's treatment.

(2) making relevant visits to the patient's home and family to assure the efficacy of the supervising psychiatrist's treatment plan;

(3) counseling the patient, if counseling is done during an office visit;

(4) conducting group therapy sessions, if conducted during an office visit.

(5) submitting regular reports to the supervising psychiatrist which will keep him informed of any changes in the patient's circumstances or condition which may influence the outcome of the patient's treatment.

(e) *Payment and reimbursement.* (1) Payment for social work services performed by a social worker shall be made only to the supervising psychiatrist. Social workers may not bill independently for their services.

(2) State reimbursement for social work services performed by a social worker shall be limited by the maximum reimbursable fees for such services.

(3) Claims submitted by a supervising psychiatrist for social work services performed by a social worker must include the name of the social worker providing such services.

(4) A visit to a social worker shall be deemed a visit to the supervising psychiatrist for the purpose of determining when a treatment plan must be filed for review by the local professional director pursuant to section 85.29 of this Part.

Title 18 of the Department of Social Services Regulations provides in pertinent part:

505.15 Psychiatric care. (a) Provision of psychiatric care may be provided *to a recipient in the Medical Assistance Program* by a qualified psychiatrist. *In the delivery of such care, a qualified psychiatrist in private practice may utilize the services of a certified social worker under his supervision as part of a course of treatment. Such care shall be provided* in [his] *the psychiatrist's* office; in the patient's home; in a clinic, a general or chronic disease hospital or approved medical institution or facility operated in compliance with applicable provisions of law; or, for persons aged 65 and over and for those under 21 years of age, in a hospital caring exclusively or primarily for patients with mental disease. In the case of a person who during the course of hospitalization attains the age of 21, such services may continue until he reaches the age of 22.

(b) *Psychiatric care by psychiatrists in private practice.* (1) *A psychiatrist may employ up to four certified social workers to provide care under his continuing direct supervision.*

(2) State reimbursement for social work services performed by a social worker shall be limited by the maximum reimbursable fees for such services.

(3) Claims submitted by a supervising psychiatrist for social work services performed by a social worker must include the name of the social worker providing such services.

(4) A visit to a social worker shall be deemed a visit to the supervising psychiatrist for the purpose of determining when a treatment plan must be filed for review by the local professional director pursuant to section 85.29 of this Part.

[LETTERHEAD OF]

NEW YORK STATE
DEPARTMENT OF SOCIAL SERVICES
40 North Pearl Street, Albany, New York 12243
BARBARA B. BLUM, *Commisioner*

January 15, 1979

Arthur J. O'Leary
Regional Medicaid Director
Region II
Department of Health, Education
and Welfare
Room 3840
26 Federal Plaza
New York, New York 10017

Dear Mr. O'Leary:

I am writing to set forth the view of this Department concerning recent correspondence between our agencies on the question of whether the Medical Assistance Program must, or may, cover services provided by certified social workers under the supervision of a physician or other medical specialist. I have enclosed some of the correspondence for your review.

It appears clear that a State *may* cover certified social workers under the Medical Assistance Program, and receive Federal reimbursement for payments for those services, where State law defines those services as within the scope of the practice of medicine. This statement is true whether the services are provided directly by a physician, or under his personal supervision.

The operative part of this statement, however, is the phrase "where State law defines those services as within

the scope of the practice of medicine." In my opinion, the services of a certified social worker are not, under the laws of New York State, within the scope of the practice of medicine. This opinion is universally shared by other officials of this Department, and has been expressed by the Department of Health.

Furthermore, the question is one purely of State law and, therefore, of State interpretation. Under the concept of the Federal grant programs, Federal officials have no interest in interpreting State laws, and no authority to interpret State laws. In this particular instance, the scope of services covered as mandated "physician services" under Federal law and regulations is left, by the same law and regulations, to the provisions of State law.

Therefore, in terms of the recent letter from Tecla Kern, Branch Chief State Operations, to Dean Higgins of my staff, I find I cannot deduce your position on this subject. The letter recites the relevant Federal regulations which make it clear that Federal reimbursement will be available where State law allows coverage of these services. The statement is then made that the "services of these professionals [including social workers] are covered for Medicaid reimbursement under "physician services" provided they are rendered under the personal supervision of a licensed physician. If this means they are "coverable" for Federal reimbursement purposes, I agree; if it means they are "covered" under this State's Medicaid program, I both disagree and assert that such a determination is not within the authority of a Federal official; in accordance with HEW's own regulations.

Further on, the letter states that "we are distinguishing between the reimbursement of social workers as inde-

pendent providers, which is clearly excluded by The New York State Plan, and the reimbursement of the psychiatrist for services rendered by such individuals employed and supervised by him, which is clearly provided for within the scope of 'physician services'." Again, if "reimbursement" in this sentence refers to Federal funding, and "provided for" means that Federal regulations allow coverage, I agree. However, if the language intends the more normal interpretation that "reimbursement" means "payment to the provider" and "provided for" means the service *is* covered under New York State's Medical Assistance Plan," then I again disagree and assert that such an interpretation of New York State Law is beyond the authority of any Federal official.

I therefore reaffirm the decision of this State that the services of a certified social worker are not within the scope of the practice of medicine in New York State, even though provided under the direction of a physician or psychiatrist; that those services cannot therefore be covered under the Medical Assistance program in this State; and that we intend to continue to deny claims for physician services that were in fact provided by certified social workers, and to recover any overpayments made on claims submitted in that circumstance, unless and until State law is changed.

I look forwarded [*sic*] to hearing your views on this matter.

Sincerely,

/s/ David P. Glasel

David P. Glasel
Deputy Commissioner
and General Counsel

Petitioner's Reply Brief

No. 81-860

Office - Supreme Court, U.S.
FILED
DEC 29 1981
ALEXANDER L. STEVAS,
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

ALVIN R. YAPALATER, M.D.,
Petitioner, Pro Se,

—v.—

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,
Respondents.

REPLY BRIEF OF PETITIONER TO BRIEFS IN OPPOSITION BY COUNTY RESPONDENTS AND BY STATE RESPONDENTS

ALVIN R. YAPALATER, M.D.
Petitioner—Pro Se
68 East Post Road
White Plains, N.Y. 10601
(914) 949-7880

QUESTIONS PRESENTED

1. Do both the State Respondents' Brief in Opposition and the County Respondents' Brief in Opposition imply that this Court does not have or should not take, jurisdiction?
2. Is the County Respondents' Brief in Opposition virtually a total misstatement of facts; is it argumentative distortion, scandalous and prejudicial, designed to obscure the issues?
3. Is the State Respondents' Brief in Opposition misstating the facts and misstating the merits to avoid coming to grips with the issues?

PRELIMINARY STATEMENT

This Reply Brief is submitted pursuant to United States Supreme Court Rule 22.5 and addresses the separate Briefs in Opposition received on December 22, 1981 from the captioned State Respondents and County Respondents respectively.*

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*References to pages in each Brief in Opposition (State Respondents and County Respondents) are prefixed SR and CR respectively; references to the Petition and to its appendix are prefixed P and A respectively.

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IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1981

No. 81-860

ALVIN R. YAPALATER, M.D.,

Petitioner,

- vs -

CHARLES W. BATES, individually and as Westchester County Commissioner of Social Services, and HENRY J. LEFKOWITS, M.D., individually and as Westchester County Department of Social Services Psychiatric Consultant; BARBARA BLUM, individually and as New York State Commissioner of the Department of Social Services; WILLIAM STEIBEL, individually and as Deputy Commissioner of the New York State Department of Social Services (Division of Medical Assistance); ROBERT P. WHALEN, individually and as Commissioner of the New York State Department of Health; ALBERT DEMARTINO, individually and as Director of the White Plains Regional Office of the New York State Department of Health; and LOIS EIL, individually and as Medical Director, Westchester County Division of Medical Assistance of the New York State Department of Health,

Respondents.

REPLY BRIEF OF PETITIONER TO BRIEFS IN OPPOSITION BY COUNTY RESPONDENTS AND BY STATE RESPONDENTS.

REASONS WHICH CAUSE THIS REPLY

1. Both the State Respondents' Brief in Opposition and the County Respondents' Brief in Opposition imply that this Court does not have jurisdiction and in the alternative should not take jurisdiction.

Petitioner denies the claims in each of the Briefs in Opposition with respect to the implication of jurisdictional defect or "unworthiness" of the issues (SR 2-3; CR 2). It is clear enough that federal questions have been raised, that jurisdiction was found by the two Court below (P 5-8; A 1-34), and that this Court was petitioned for Certiorari on the same jurisdictional predicates as below within the statutory time limit. Further, with respect to Rule 17 of this Court, it has been sub-

mitted that the Petition's Questions Presented for Review are vital with respect to the "concept of welfare or the opposite [Page 17 paragraph 12]", the legislative intent of the Congress, governmental interference with contitutionally protected rights, bureaucrats' undermining of state legislative intentions, the authority of H.H.S., the applicable provisions of the Social Security Act. It is further submitted that it is plain that the United States Court of Appeals for the Second Circuit extended itself to make the Petition possible (A 7 - A 9), by motu proprio "Treating the 'Motion to Reenter Judgment' as a petition for rehearing..."

2. The County Respondents' Brief in Opposition is virtually a total misstatement of fact, is argumentative

distortion, scandalous and prejudicial, is designed to obscure the issues.

Petitioner denies the "facts" interlaced with argument in this Brief in Opposition which in toto blurs the causes of action with inaccuracies and irrelevancies which did not succeed in the trial court. Whereas this Petitioner did not conduct a discovery, these Respondents did conduct a discovery of Petitioner within this action; that discovery concerned not only the person and private practice of the Petitioner, but concerned also the person of Psychiatric Services Center, Inc. ("PSCI"). References which are scandalous and prejudicial to this Petitioner are through out these Respondents' brief (CR 4 - CR 12). Despite Respondents' utilization of these tactics in the courts below and, most sur-

prisingly, their continued use of the same tactics here, the trial court, has stated:

> "[Petitioner] appears to me from the evidence to be an experienced and dedicated physician." (A62) (underlining supplied: see also A 84 paragraph 1)
>
> * * * * * * * * * * * * *
>
> "Considerable reference was made at trial to Psychiatric Services Center Inc....None of the issues is pertinent to the case at bar." (A 88)

It is submitted that County Respondents' evaluational references to the transcript are unfair and presumptuous (CR 5 - CR 12). Moreover, the Respondents' characterizations and inaccuracies (CR 6 - CR 12) must be termed a coarse attack which is seen to border on hysteria if read along side the trial court's memorandum opinion (A10-A94). This Court's time should not be engaged

with a counter-counter attack with respect to PSCI, which is irrelevant within this action. However, this irrelevancy is used by these Respondents in the service of an improper personal attack by virtue of slanted and/or patently incorrect statements. For instance, those court decisions referenced in footnote on p. CR 6, if read in their published form immediately make clear that PSCI can not be termed, as the Respondents have done on p. CR 6, "...a methadone program employing as therapists persons of questionable qualifications..." (underlining supplied), but was concededly "...properly licensed to perform those services [psychiatric care] and may be entitled to reimbursement for other services furnished Medicaid patients" (PSCI v. Bates, 436 N.Y.S. 2d 702, 52 N.Y. 2d 788 (1980)).

Respondents assert on pp CR 7 - CR 8:

> "Petitioner admitted that he was on behalf of PSCI submitting bills to the [County] for patients who were being treated by PSCI, for whom PSCI submitted bills in the past, and for whom the County was refusing to pay PSCI (T: 261-62, 264-65, 268-70)"

The foregoing is patently incorrect not only in content but also with respect to source: Alfred J. Vent, M.S.W., C.S.W., a social worker, is the subject of direct examination on those referenced and misrepresented transcript pages. Further, the respondents' characterizations with respect to "laundering" of claims (CR 7, 12) border on slander and are ridiculous. As respondents put it: "Surely after three days of trial, if

facts establishing...[Respondents'] claims were in existence, they could have been introduced." (CR 12).

Petitioner does not understand how these respondents can persist in a device which availed them no more than a footnote within the trial court's memorandum opinion (A 88).

Lastly, the Respondents' "argument" (CR 10 - CR 12) purportedly adjudges "the record below" as "...sorely lacking in facts tending to establish that petitioner complied with Medicaid regulations including requirements of supervision of ancillary personnel." With respect to this argument, we believe that it is the Court's province to evaluate the sufficiency of the record below: also, we believe that a review of the bureaucrats' position and understanding with respect

to supervision (A 171 paragraph 2) as reported to the state legislature, indicates that these Respondents are insincere. Evidence was brought out at trial with respect to this Petitioner's treatment practices; see A 62 paragraph 2; A 84 paragraph 1.

3. The State Respondents are misstating the facts and misrepresenting the merits in order to avoid coming to grips with the issues.

With respect to the Respondents' use of the facts, the Respondents are incorrect in claiming that the "Questions Presented for Review" are improper in that they raise issues which...were not raised in the Courts below" (SR I). It is clear from the trial court's Memorandum Opinion and Order (A 10 - A 94) that the Questions had to have been raised below. Further, the Respondents apparent-

ly belie their own contention when they later claim that [p]etitioner seeks review...on the identical arguments presented below." (SR 9). Respondents are incorrect in their own listing of the Federal and State "statutes and regulations which Petitioner has placed in issue" (SR 3 - SR 4). In fact, the Petition places many more statutes and regulations in issue; inter alia (P 7) 42 USC 1320a - 2*/Title XI (P 20 - P 22; A 202 - A 204); State Plan Under Title XIX of the Social Security Act Medical Assistance Program p.1 (P 10, P 18, P 20, A 259); 42 USC §1983.

Respondents are factually incorrect where they state that "Title XIX...

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*Added October 30, 1972 as §1123 of the Act (A 276).

establishes the framework for state-operated Medical Assistance (Medicaid) programs" (SR 5); this is not entirely it. Title XI (42 USC subchapter XI, viz §1320a-2 also governs, as does the State Plan which itself is a document separate and distinct from the New York Social Services Law; vide: supra. Thus, the Respondents are incorrect also, in attempting to portray "('State Plan')" as identical with the "New York State Medical Assistance Program " and "(New York Social Services Law, Title II, §363 et seq.)" (SR 4 paragraph 3); See also A 234 - A 236 et seq. Thus, prior to its revision 18 NYCRR 505.15 (SR 4a) did not on its face restrict psychiatrists as did the bureaucrats who acted outside the State Plan and 42 USC 1396a (a)(23) et al.

With respect to the Respondents' admitted use of argument, the Petitioner addresses the Respondents' reasons for denying the Petition (SR 9 - SR 11). This Court holds that strict judicial scrutiny is required where a statutory scheme is operated so as to impinge upon a fundamental right explicitly or implicitly protected by the Constitution. Such rights are involved here. The most obvious right is that of a psychiatrist to practice his profession vis a vis all prospective patients with the clinical team approach which is the creation of american psychiatry dating back to the year 1905. At that time, psychiatrists in New York and in Boston hired "agents" to assist in treatment of patients and their families.*

*Encyclopedia of Social Work, 17th Issue NASW, 1977 p.899 paragraph 2; see also A 199 paragraph 2.

Now the bureaucrats in this state defy the legislative intent of the Social Security Act and of the New York State Education Law and illegally create a scope of medical practice which illegally impinges upon physicians' licenses and right to treat human disease according to sound clinical practice (P 23 - P 28). Further it is incorrect to say as Respondents do: "[n]or is reimbursement to providers of Medicaid services a fundamental right protected by the Constitution (SR 9). The Second Circuit has held that: "...Title XIX...created expectations on the part of both consumers and providers of health care...government can not terminate Medicaid payments without providing notice of the reasons for termination to the person who is to be deprived of the statutory entitlement and

a hearing before an impartial fact finder in which that person can attempt to rebut the charges against him. See, e.g. Goss v. Lopez, 419 U.S. 565, 572 - 573, 95 S.Ct. 729, 42 L.Ed.2d 725 (1975); Arnett v. Kennedy, 416 U.S. 134, 164, 94 S.Ct. 1633, 40 L.Ed.2d 15 (1974) (Powell, J., concurring); Board of Regents v. Roth, 408 U.S. 564, 576 - 578, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972)..." Hathaway v. Mathews 546 F. 2d 227 (1976) p. 230 paragraph [4]. It is to be noted that the facts in Hathaway entirely distinquish it from this Court's finding in O'Bannon v. Town Court Nursing Center 100 S.Ct. 2467 (1980) where the government fulfilled, equitably, constitutional requirements for the provider.

Respondents' claim that "[p]etitioner seeks review...on the identical

arguments presented below" (SR 9) is incorrect. There is extensive research and statutory analysis more present here which was less present below; this is obvious from the content of the challenges raised as compared with the trial court's Memorandum Opinion and Order. It is submitted that these challenges show here as they should have below that the trial court was incorrect on the law and misinterpreted the concerned legislative intentions with respect to the issues. Further upon the evidentiary material before it, the trial court's findings of fact were incorrect.

What the Respondents are arguing at SR 10 - SR 11 is a thinly disquised effort to preserve the "luck" they had in crippling H.H.S. The "O'Leary letters" were beyond the stages of guide-

lines or regulations. A reading of the pertinent regulations in 45 CFR §§ 201.2-204.2 (A 234-257) means that a "compliance issue" was being processed predicated upon 42 CFR 440.50 and upon authority H.H.S. derived from the Social Security Act: cf. 42 USC 1320a-2. The Respondents, when finally worn down, created the Social Worker provision (SR 4a), but still undermined by setting fees at unworkable levels (P 30).

Shortly after the Respondents indicated on February 29, 1980 that they would concede on this Social Worker issue, HEW Regional Medicaid Director O'Leary addressed Commissioner Blum by letter:

> "...The exclusion of other professionals and paraprofessionals (i.e. psychologists, therapists) violates the definition of physicians' services..."

The Respondents have for years been intimidating psychiatrists who have attempted to offer to medicaid recipients the same services offered to self-supporting patients (A 77 paragraph 2; A 199). Illegally on many counts, the Respondents have fostered their unrealistically expensive psychiatric monopoly where cost-based service sessions often run about one hundred dollars. This single cost-factor is violative of 42 USC 1396a(a)30 (A 213 - A 214; Bay Ridge Diagnostic Laboratory v. Dumpson 400 F.Supp. 1104 E.D.N.Y., 1975) pages 1110 - 1111), and is not an untouchable question of "wise economic or social policy" (A 83 paragraph 1).

Lastly we think, in disagreement with the Respondents (SR 10), that the H.H.S. position has been shown to be

consistent with Title XIX and Title XI as well as with its own regulations and prior pronouncements. We can not say why the trial court missed the obvious inconsistencies and discrepancies between the Respondents' articulated position within the litigation and the material at A 163 - A 201, but we do say that the courts below should review or be reviewed inasmuch as the consequences and depths of the issues are of capital magnitude for Medicaid and for the rights of physicians everywhere to exercize their vested right to practice within the current and historical scope of their professions and professional licenses.

Where bureaucracies have enough power tc protect the public by enforcing the intentions of the legislatures, self-serving bureaucrats should not be per-

mitted to strangle the public, or those professionals which serve, through the imposition of additional discriminatory, fiscally detrimental self-aggandizing requirements of their own devising; People v. Dobbs Ferry Medical Pavillion (40 A.D. 2d 324. pp. 327 328, 330 and passim; aff 33 N.Y. 2d 584). People v. Dobbs illucidates that the Respondents, state-wise, are arguing for whimsical restrictions based upon laws which have been not only previously misused by them but which also have been found unconstitutional, "as written". Here again in the same way the Respondents are attempting to find rational basis where there is none.

CONCLUSION

For the foregoing reasons and upon this Reply Brief, the petition for a writ of certiorari should be granted.

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Respectfully submitted,

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